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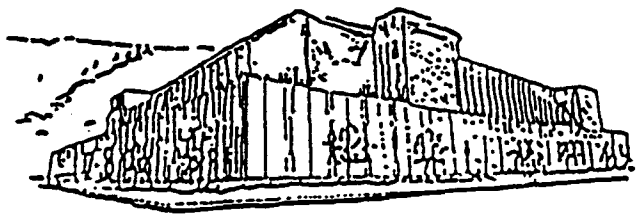
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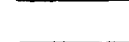
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STRATEGIC LEADERSHIP IN UNIVERSITY
WELLNESS PROGRAMS

by

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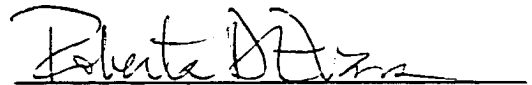
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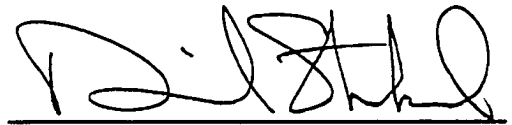
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Strategic Leadership in University Wellness Programs

Chairman: Dr. Roberta Evans 

Health promotion and wellness programs are commonly used to offset the increasing costs of employee health care. Although the scope and breadth of programming varies, wellness programs have been proven to decrease overall costs, reduce absenteeism, and increase employee morale. Worksite health promotion offers the potential of affecting the health of the individual worker along with the health of the organization. Strategic leadership types in university wellness and health promotion programs were studied.

The primary purpose of this study was to investigate strategic leadership theory as applied to directors of university wellness programs. Specifically, Nahavandi's (1997) strategic leadership model and theory were used to determine whether or not a relationship existed between the breadth and scope of wellness programs and the level of strategic leadership exhibited by their directors. This study used mixed-methodology taking advantage of both quantitative and qualitative approaches data for the purposes of triangulation and expansion of findings.

For phase I, a random sample of 50 university/college wellness directors was drawn from the *1998-2000 NWIRC Directory: Wellness in Higher Education*. For phase II, the sample consisted of eight directors who volunteered to participate in post hoc interviews. This study found that most (72%) of the university wellness directors were categorized as Participative Innovators, and 25% were identified as High-Control Innovators. Significant difference ($<.05$) was found between HCI and PI leaders and their level of "need for control." No significant differences were found between the organizational structure, organizational culture or strategy of HCI and PI leaders. This study concluded that innovators, by nature, had been drawn into the leadership of wellness; that they tended to stay in their positions overtime; that they are simultaneously participative and controlling in the planning process; and that they are creative instead of complacent in the face of budgetary reductions.

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New adventures always bring change and growth and unexpected pleasures – and this endeavor was no different. To the members of my cohort “team,” thanks for the laughs, memories, and support. Special thanks to Dr. Deb Yerkes, and Dr. Mark Neill, who were always there for me - emailing and phoning support and encouragement. Special thanks go out to my dear friend, Ms. Jodi Moreau, who from the day I met her has been hiding “wings.”

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CHAPTER ONE

INTRODUCTION

Wellness and/or health promotion programs have been conducted in a variety of settings for decades. Most recently, the worksite has become a major focus of health promotion efforts. Worksite health promotion programs have progressed from simple, single-offering programs designed to address one dimensional risk factors to highly coordinated, comprehensive programs designed to address major health problems with multiple and interactive causes.

In the United States, one hundred million adults spend one-third of their lives at the worksite, making the workplace an ideal environment to promote health behavior (DeJoy & Wilson, 1995). Although some worksites have provided health promotion opportunities for many years, the trend did not emerge nationally until the late 1970s. Most organizations engage in health promotion efforts as a strategy to control health care costs, to maximize employee productivity and satisfaction, and to heighten the company's overall competitive position within the marketplace.

Worksite health promotion offers the potential of affecting the health of the individual worker along with the health of the organization and community. The majority of illnesses influencing mortality and premature death are related to lifestyle; therefore, prevention and modification may be the best defense in the fight against disease.

Leadership in the field of health education/health promotion is a new endeavor. According to Brink (1997), although no formal data are available, anecdotal discussions suggest that few health educators have participated in leadership training. A number of

national and international health education and health promotion organizations have defined leadership training as a top priority for their organizations (Brink, 1997).

Good health depends to a large extent on certain lifestyle choices people make including: what they eat, how active they are, whether or not they smoke, the precautions they take to avoid injuries and accidents, how they deal with stress, and even how they manage the environments in which they live and work. The type of leadership given at the worksite can influence health and lifestyle choices made by employees within that environment.

Statement of the Problem

Worksite health promotion programs constitute a relatively new concept. Much of the research conducted on worksite health promotion or wellness programs has focused upon the types of health-related programs offered, as well as cost-containment and implementation. Clearly, studies have shown dramatic increases in the scope and breadth of wellness offerings, as evidenced by their increasing popularity and fiscal gains. Additional research has forecast a growing need for even more comprehensive programs and speculation regarding as yet unseen organization benefits. While such research is useful in establishing a thorough description of available services, to date there has been no research investigating the quality or nature of leadership in wellness organizations, yet this role is critical to the vision and mission of wellness. Leadership characteristics and/or tendencies must be considered, ascertaining the organizational needs and how the leadership style of the director impacts future programs. If the nature of this relationship

affects the overall quality of the program and its ability to implement and plan for future needs, revisions in the selection and matching processes of wellness directors may be warranted.

The Purpose of the Study

The purpose of this study was to investigate strategic leadership theory as applied to directors of wellness programs. Specifically, this research was used to determine whether or not a relationship exists between the breadth and scope of wellness programs and the level of strategic leadership exhibited by their administrators. This study was guided by two major research questions: First, what type of strategic leaders are found in university wellness programs? Second, how is strategic leadership related to the programming and future planning of university/college wellness health promotion programs? Findings were elicited through a two-phase study involving both quantitative and qualitative methodologies.

Research Questions and Subquestions

The following questions shaped this investigation:

1. What type of strategic leaders are found in university/college wellness/health promotion programs?
2. How is strategic leadership related to the programming and future planning of the university/college wellness/health promotion program?

Subquestions

1. Is the type of organizational structure of the university wellness/health promotion program associated with the leader's strategic leadership style?
2. Is the organizational culture of the university wellness/health promotion program related to the leaders' strategic leadership style?
3. What is the nature of the future planning process implemented by different types of strategic leaders?

Delimitations of the Study

This study was confined to those directors of university/college wellness/health promotion programs, identified as offering faculty/staff wellness programs, listed in the *1998-2000 National Wellness Information Resource Center Directory: Wellness in Higher Education*.

Limitations

The quantitative phase of this investigation relied upon Dr. Afsaneh Nahavandis' instruments: *Your Organization, What Is Your Strategic Leadership Type?* And the *Strategic Leadership Scoring Grid (1997)*, which is currently undergoing a variety of tests for validity and reliability. However, insofar as this is a new assessment on leadership, this study also served to enhance the body of literature providing information on its validity and reliability. Further, the qualitative methodology of Phase II meant that these findings

are not generalizable. Nonetheless, this phase greatly informs existing knowledge in the area of wellness program leadership.

Your Organization and *What is your Strategic Leadership Type* are instruments newly emergent in the literature, therefore, they have not yet undergone in-depth validation procedures. At this time, they are concurrently being utilized in several investigations; however, this work is limited by its qualified validity.

Definition of Terms

The following terms are defined for use in this study:

Comprehensive Wellness Program. Those programs which feature “multiple and coordinated activities and which give serious attention to organizational and environmental supports for behavioral change” (DeJoy & Wilson, 1995, p. 9).

Cost-Benefit. A measure of the cost of an intervention relative to the benefits it yields, usually expressed “as a ratio of dollars saved or gained for every dollar spent on the program” (Simons-Morton, et al, 1995, p. 238).

Cost-Effectiveness. A measure of the cost of an intervention “relative to its impact, usually expressed in dollars per unit of effect” (Simons-Morton et al, 1995, p. 238).

Cost-Sharing. The movement of either “premium or claims costs from the employer to the employees. It may result in fewer services” (Chapman, 1996a, p. 116).

Employee Assistance Program. “An organized consultation program intended to assist the troubled employee whose job performance is impaired or likely to be impaired” (Chapman, 1996a, p. 118).

Health Risk Appraisal. An instrument that requires people to answer a number of questions about “their health behavior, health history, and the results of a few clinical screenings (height, weight, blood pressure, and total cholesterol amount). This information is then entered into a computer that has been programmed to compare the entered data against a database that contains information from individuals of the same gender, race, and age. The results of such a comparison tells people their risk of dying from the leading causes of death as compared to others of the same gender, race, and age” (McKenzie & Jurs, 1993, p. 41).

High-Control Innovator (HCI). One of four types of strategic leaders, defined by Nahavandi (1997). The HCI leader is a challenge seeker who “likes to maintain tight control over organizational functioning. This type of leader will look for risky and innovative strategies at both the corporate and business levels” (Nahavandi, 1997, p. 232).

Leader/Manager. These terms will be used interchangeably, referring to people who occupy positions “in which they are expected to exert leadership, but without any assumption that this process actually occurs” (Yukl, 1994, p. 5).

Lifestyle. A style of living that consistently reflects a particular set of values and attitudes (Hurley & Schlaadt, 1992).

Micro Leaders. Micro are those leaders who are concerned with small groups or small departments, their focus is “typically internal to the organization on factors that affect their teams or departments” (Nahavandi, 1997, p. 210-211).

Organizational Culture. In a worksite environment, the shared values, beliefs, norms, and assumptions that guide (often unconsciously) the behaviors of members of the organization (Mainiero & Tromley, 1987; Schein, 1985).

Organizational Structure. Organizational structure is often “influenced more by assumptions about internal relationships for effective adaptation to the environment. A centralized structure reflects the belief that only the leader can determine what is best, whereas a decentralized structure reflects a belief in individual initiative and shared responsibility” (Yukl, 1994, p. 357).

Participative Innovator (PI). One of four types of strategic leaders, defined by Nahavandi (1997). The PI leader will seek challenge and innovation on the outside and create a loose, highly open, and participative culture and structure inside the organization.

Preventive Health Behaviors. Health practices that promote wellness and “prevent or reduce morbidity and mortality” (Anspaugh, Hamrick, & Rosato, 1997, p. 11).

Process Manager (PM). One of four types of strategic leaders, defined by Nahavandi (1997). The PM leader prefers conservative strategies that stick to the tried and tested.

Recidivism of Health Behaviors. A high percentage of individuals who enter programs for health behavior change “relapse to their former behaviors” (McKenzie & Smeltzer, 1997, p. 115).

Snowball sampling technique. Asking the first person you interview to recommend others (Bogdan & Biklen, 1992).

Status-Quo Guardian (SQG). One of four types of strategic leaders, defined by Nahavandi (1997). The SQG leader needs control over the internal functioning of his or

her organization and is risk averse. Status-Quo Guardians are sometimes viewed as quality control managers.

Strategy. Overall, the strategy of an organization is how it achieves its vision, mission, and goals. Strategy consist of an integrated, cohesive plan for achieving an organization's short-term and long-term objectives (Quinn, 1980).

Upper-Echelon Leaders. Leaders that have jurisdiction over entire organizations that include many smaller groups and departments. Upper-echelon leaders have discretion and power over many decisions (Nahavandi, 1997). University wellness directors are considered upper-echelon leaders who set policy for their organization.

Wellness. “[E]ngaging in attitudes and behaviors that enhance quality of life and maximize personal potential” (Anspaugh, Hamrick & Rosato, 1997, p. 5).

Wellness Incentive Rebates. Incentive features which utilize “financial rewards for prudent health service use and healthy lifestyle choices” (Chapman, 1996a, p. 74).

Wellness Program. An organized program intended to assist employees (and their family members) in “making voluntary behavior changes and/or taking actions which reduce their health risks and/or enhance their ability to perform. Typically wellness programs address physical activity, nutrition and dietary practices, stress management, smoking cessation, safety practices and hypertension screening” (Chapman, 1996, p. 128).

Worksite Health Promotion. The combination of “educational, organizational and environmental activities and programs designed to motivate and support healthy lifestyles among a company's employees and their families” (Chenoweth, 1998, p. 5).

Significance of the Study

As described fully in Chapter Two, current literature reflects the rapidly changing nature of wellness/health promotion programs in the United States. Worksite health promotion programs clearly reduce the cost of health care (Chapman, 1996b). Indeed, prevention has been identified as one of the best ways to eliminate many unnecessary medical problems. Further, current studies on worksite health promotion programs strongly recommend organizational strategic planning as well as implementation plans for increasing the scope and breadth of wellness programming (Chenoweth, 1998).

While the literature in the area of wellness programming provides rich detail regarding specific programs, to date, no studies have examined any aspect of wellness programming leadership. Yet, an emerging program vision requires strategic leadership. Therefore, this study sought to fill a significant void in the literature by investigating the relationship between strategic leadership attributes and successful wellness organizations. Such knowledge enables all wellness organizations to optimize their planning processes in better meeting the health needs of people everywhere.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

THE CONCEPT OF WELLNESS

Background

The concept of what it means to be healthy has changed. Many people believed that if they were not sick, they were healthy, that good health was simply the absence of illness, and of *health care* [italics added] as efforts by medical personnel to cure people who were sick. We became increasingly aware that the best medical care, while certainly beneficial, was not sufficient to preserve and enhance health. To accomplish this, we needed to take a more active approach. Wellness programs have attempted to do this in two ways. First, wellness promotes a way of living that stresses taking steps to prevent illness and prolong life. In addition, wellness represents an optimum state of health and well-being that each individual is capable of achieving, given their unique circumstances.

We have seen incredible advances in medical technology over the past few decades, including the development of new drugs and new diagnostic and surgical procedures. Unfortunately, these new discoveries have a downside, drugs may be prescribed too readily, excess numbers of diagnostic tests are ordered, often we experience overcrowded and impersonal hospitals, and the cost of health care has soared.

When you consider that the majority of illnesses influencing mortality and premature death are related to lifestyle, prevention and modification may be our best defense in the fight against disease. By modifying risk factors such as exercise, poor diet, use of tobacco and drugs, and alcohol abuse, the United States Department of Health and

Human Services (USDHHS, 1990) reported that Americans could prevent between 40 and 70% of all premature deaths, one-third of all acute disabilities, and two-thirds of chronic disabilities.

The average life expectancy for Americans continues to climb, however, according to Chenoweth (1998) our health status has not improved. In fact, in many ways we are worse off than we were a decade ago. Growth in the number of women smoking increases the risks of lung cancer, heart disease, and other smoking-related ailments. And, despite the plethora of low-calorie, fat-free foods and exercise options, more American adults are obese now than ever before.

Americas health habits are reflected at the worksite. A 1997 survey of over 400 business owners nationwide suggested that every business has employees with health problems. The top ten risks indicated in the survey, ranked in order of frequency were:

1. Excess stress
2. High Blood Pressure
3. Cigarette smoking
4. Back Injuries
5. Overweight
6. Alcohol Abuse
7. High Blood Cholesterol
8. Drug Abuse
9. Depression, and
10. Mental Health Problems (Chenoweth, 1998).

The clear conclusion of this and other studies was that we are not dependent on medical breakthroughs to achieve an enormous improvement in our health. Rather, good health depends, to a large extent, on certain lifestyle choices we make including: what we eat, how active we are, whether or not we smoke, the precautions we take to avoid injuries and accidents, how we deal with stress, and even how we manage the environments in which we live and work. It is these choices, among other concerns that Worksite Health Promotion (WHP) targets in order to help employees make wiser and healthier decisions about their lifestyles.

History of Employee Wellness

Well ahead of his time, John H. Patterson of the National Cash Register Company had an understanding of the importance of healthy and fit employees. As early as 1894, Mr. Patterson introduced morning and afternoon exercise breaks to his employees. Within ten years his fitness program was expanded to include a gym, and in 1911, he opened a 325-acre park for the benefit of his employees (Chenoweth, 1998; Maryk, 1982). While Mr. Patterson was making strides toward promoting healthier employees, interest at other levels was being generated.

Mindful of the economic loss to industry caused by illness, President Theodore Roosevelt in 1906 appointed a committee of 100 to study “the national vitality.” After two years of research, the committee submitted its findings and recommendations to Congress and then-President Taft. Their recommendations included the institution of an educational program to encourage people to have regular health examinations to detect

disease before it became disabling and to correct unhealthful habits of living. Through the years these ideas grew and as early as the 1920s many companies were sponsoring sport teams and providing opportunities for employees to pursue recreational interests such as bowling, tennis and softball (Saxl, 1984). In 1941, one of the first national organizations was developed. The National Employee Services and Recreation Association (NESRA) was formed and spearheaded greater interest in employee health. Other organizations followed suit, with PepsiCo establishing its physical fitness program in the late 1950s, and American Can and NASA beginning in 1968 (Chenoweth, 1998).

The National Aeronautics and Space Administration (NASA), in conjunction with the U.S. Public Health service, initiated a health evaluation and enhancement program in 1968. This exercise program was developed first, in an effort to assess the feasibility of establishing an effective exercise program within the employment setting of a federal agency; second, to identify the factors that influenced joining, adherence to and effectiveness of the program in modifying selected cardiovascular risk factors, health attitudes and behavior; and finally to provide guidelines for the future development and administration of effective exercise programs within government and industry (NASA, 1972).

The participants could choose from three kinds of physical activity. In all three programs, participants were expected to exercise for thirty minutes three times per week. After a year, participants completed a questionnaire and were given a physical examination. Of those adhering to the program, 50% reported having a more positive work attitude along with improved work performance; 92% reported a feeling of overall better health; 60% reported weight loss; and 50% admitted to feeling less stress and

tension. NASA concluded their study by stating, “participation in a preventive health program can influence how a person thinks and feels and what he does about promoting health and preventing disease” (NASA, pp. 789-790).

By the early 1970s, the fitness craze was well underway. The human body had become an enduring and perhaps historically significant national obsession. In the late 1970s, Kimberly-Clark Corporation and Sentry Insurance built state-of-the-art fitness facilities, with many other companies following suit throughout the 1980s. Today NESRA, along with many other national organizations, exist in an effort to keep their members informed of the latest development in wellness and health promotion strategies. These organizations include: Association for Worksite Health Promotion (AWHP); National Wellness Council of America (WelCOA); American Fitness in Business (AFB) and the National Wellness Association (AWA). Each organization offers a variety of membership options for individuals and businesses. According to Chenoweth (1998), it is estimated that over 50,000 organizations house on-site physical fitness programs in the United States with nearly 1,000 employing full-time program directors.

The U.S. Government continued to promote wellness in the workplace as evidenced in the goals of *Healthy People 2000* (1990), where prevention for business, community, and labor leaders, was encouraged for the mutual benefit and well-being of employees and their communities. This document addressed postsecondary institutions and workplaces with 50 or more employees that offered health promoting activities for students, faculty, and staff. Two of the goals that specifically addressed the worksite included, first, increase (to at least 85%) the proportion of workplaces with 50 or more employees that offered health promoting activities for their employees, preferably as part

of a comprehensive employee health promotion program. Second, increase (to at least 20%) the proportion of hourly workers who participated regularly in employer-sponsored health promotion activities (p. 102).

With interest in worksite health promotion and disease prevention increasing exponentially over the past two decades, the U.S. Office of Disease Prevention and Health Promotion (USODPHP) funded two national surveys. The first survey in 1985 concluded that the worksite has becoming a major provider for health promotion (USODPHP, 1987). Another survey, done in 1992, provided insight into the continued growth of worksite health promotion programs, along with information as to the effect of worksite health promotion in the nation. The 1992 survey indicated that 81% of worksites with 50 or more employees offered at least one health promotion activity to their employees, compared to just over 68% in 1985. According to this survey, 99% of all large companies and 75% of most small companies offered health promotion activities (USDHHS, 1992).

In the United States, the employee wellness movement has continued to gain momentum and will continue to grow through the 1990s and into the 21st century. With an increase in individuals accepting and adopting a wellness program, worksite health promotion has increased greatly over the past two decades. What began as a somewhat rare corporate “perk” has fast become a necessity in the increasingly competitive culture of the American business community.

Benefits Of Worksite Health Promotion Programs

Today, most adults spend the major portion of their day at the worksite.

Consequently, worksites provide a captive audience for promoting health and a natural opportunity for reinforcing the adoption and maintenance of positive lifestyle behaviors. This resulted in dramatic increases in wellness program scope and breadth.

There are numerous tangible and intangible benefits of an employee wellness program. It is important to recognize these benefits and understand how they reflect on an organizations' performance. An over-emphasis on one type of benefit to the exclusion of another usually leads to eventual conflict and controversy in the program's operation and future. Chapman (1996b) identified some of the major tangible and intangible benefits of employee wellness programs as:

Tangible Benefits

- Reduction in sick leave absenteeism
- Reduced use of health benefits
- Reduced workers' compensation cost
- Reduced injury experience
- Reduced disability management costs

Intangible Benefits

- Improvements in employee morale
- Increased employee loyalty
- Less organizational conflict
- More productive work force
- Improved decision-making ability

Both the tangible and intangible benefits of an employee wellness program provide evidence regarding the value of prevention and health management. Wellness is truly an

investment in the future of an organizations employees. It is much more cost-effective for organizations to prevent illness than it is to wait until the employee is afflicted with a disease related to lifestyle.

Cost-Containment

The wellness movement is especially evident in the corporate search for alternatives to subsidize the cost of health care for employees. One alternative has been to provide health-promoting programs and policies. The focus of worksite health promotion, or wellness programs is to decrease utilization of health care dollars, to decrease employees' risks of acquiring chronic illness, to enhance well-being, and potentially to decrease overall health care costs (Compton, 1991). Business' share of America's total health care bill has increased from 18% in 1965 to more than 30% in 1997, with over 50% of business profits spent annually on employee and dependent health care (Chenoweth, 1998).

Health care cost inflation has slowed over the past ten years, although it has continued to rise nearly twice as fast as general inflation. Lost economic productivity related to illness and early death has compounded the impact of this problem, so that in 1990 the total costs of illness equaled nearly 18% of Gross National Product (GNP). Injury alone costs the nation well over \$100 billion annually, cancer over \$70 billion, and cardiovascular disease over \$135 billion (Chenoweth, 1998; *Healthy People 2000*, 1992). According to Chenoweth, if this trend continues, health care spending could consume

nearly 20% of the nations Gross National Product within a few years. This compares to 12% in 1990.

The most commonly cited reason that companies offered health promotion programs was to decrease the level of health care costs and their rate of growth (Bly et al., 1986; Opatz et al., 1987; Pelletier, 1993; Popp, 1989). O'Donnell (1988) cited three primary motivations for employers to invest in health promotion programs: to reduce medical care costs, to enhance productivity, and to enhance the image of the company. Prevention is now viewed as the cost-efficient path to containing medical care costs, making health education and wellness a growth field. As evidence accumulates that prevention efforts are frequently more cost-effective than enforcement or curative approaches, trends in prevention will continue.

Wellness programming is one approach to controlling health care costs in America. Baun (1986) demonstrated that at Tenneco, female exercisers' average combined health care costs were 58.3% lower than female non-exercisers'. Average combined health care cost for male exercisers' was 44% lower than male nonexercisers', and the combined male and female per capita health care costs were 47.2% lower for exercisers versus non-exercisers. Tenneco also reported 20% lower absenteeism among male exercisers than non-exercisers, and 46.8% lower absenteeism among female exercisers' versus non-exercisers. To clarify these savings, consider the following example: a corporation had 25 female exercising employees whose average health care costs per person were 5,000 dollars per year, totaling \$125,000. This same corporation had 25 non-exercising female employees whose health care costs had an additional 58.3% added to that yearly 5,000 dollar average. The corporation would pay an additional \$2,915 per employee or

\$72,875. This translates to a total of \$197,875 per year for the 25 non-exercising women.

Chapman (1996b), after analyzing 30 original research articles, determined “carefully designed studies consistently show a cost/benefit ratio between 2.15 and 5.64 over a three to five year period for comprehensive or broad based wellness program effort employing organized communications, health & fitness testing, group activities and creation of a supportive environment for wellness behaviors” (p. 85).

Conventional wisdom indicates that health promotion and disease prevention programs are sound financial investments and therefore cost-beneficial. However, many scholars have challenged that wisdom based on questionable evaluation issues and the indirect costs associated with the net financial benefits. Those costs are associated with long term health care, pension, and disability costs incurred by employees who remain on the job in their late years or live longer into their retirement due to the success of health promotion programs. Pelletier (1993), after reviewing many published health promotion and disease prevention programs at the worksite, reported the following:

From 1980 to 1991 there were 24 published studies evaluating the health and, in some cases, the cost benefits of comprehensive health promotion and disease prevention programs in the worksite. In those previous studies, all 24 indicated positive health benefits and every study which analyzed for cost effects and/or cost benefit demonstrated a positive effect. As one measure of the growth of interest in worksite programs as integral, and arguably the single most important influence, in managed care is the fact that there were 24 new studies conducted

between 1991 and the early part of 1993. More and better designed studies were conducted in the last two years than for the entire decade of the eighties. What is even more important is the research design, data analysis, and intervention sophistication is greatly improved in these more recent studies. In reviewing the most recent 24 studies, all but one evidenced positive health outcomes. Again, of the studies which analyzed cost-effectiveness or cost benefits, every one indicated a positive return. When anyone cavalierly dismisses 48 studies with the glib dismissal of 'there is no evidence,' they are simply ignorant of more than 13 years of increasingly sophisticated research with documentation of both health and cost outcomes (p. 55).

Although reported cost savings may not have been as substantial as behavioral and risk reduction changes, most health promotion programs reported economic benefits.

Programming that improves the health of participants (particularly those at high risk), that addresses injuries and accidents on the job, and that encourages more appropriate utilization of health care services will impact health care costs. Productivity is improved by health status, but perhaps more importantly by employee attitude, including job satisfaction, respect for employer, and concentration on the job. Access to a health promotion program has been perceived by employees as a benefit, which increases their satisfaction with the company. Utilization of the program has lead to both improved employee attitudes and health. Corporate image has been enhanced by awareness of the program within the community. This has been shown to increase company visibility and demonstrate concern for employees (O'Donnell, 1994).

Employers who provide health promotion programs may be viewed in a positive way by those employees who participated. Skeptics, on the other hand, believed that employers did not have a genuine concern for improving the health of their employees or America as a society, but were interested only in the bottom line. Compton (1991) studied 19 employees participating in the employee wellness program at Montana State University. The participants in this study spoke very favorably about the University for making the program available. These participants experienced satisfaction, were compliant with the program, and spoke positively about their program experience. Since the stated objective of the Montana State University Employee Wellness Program was to promote health-enhancing behaviors, the program was judged to be cost-effective. The combination of rising costs along with the percent of those costs absorbed by an organization makes health promotion a promising opportunity for business.

Program Scope/Staffing

The scope, breadth, and structure of a worksite health promotion program varies by size of the organization, available resources, management preferences, and industry type. For example, fitness facilities are often found in large organizations with a white-collar workforce, often the home office of a large corporation. The programs offered in these organizations may be primarily fitness-oriented or may be more comprehensive. Organizations without fitness facilities often contract with private or community facilities for services.

A broad worksite program will usually include fitness, nutrition and weight management, stress reduction programs, smoking cessation, and preventative health education and screening. The depth of programs range from communication and awareness (i.e., newsletters, health fairs, screening without feedback), behavior and life-style modification (i.e., offering weight-loss or smoking cessation programs), and the creation of supportive environment for health promotion (i.e., physical setting, corporate policies, corporate culture) (Simons-Morton, B. G., Greene, W. H., & Gattlieb, N.H., 1995). The fewer available resources, and the size of the organization will dictate the intensity of the programming. An employee advisory committee, composed of employees from all levels, provides a link to the employee population. This advisory council can provide a key resource in understanding the needs and desires of the employees.

The staffing of the health promotion program depends on the services offered. According to Simons-Morton, et al. (1995), for fitness assessment and exercise leadership, a fitness professional should be hired. The American College of Sports Medicine (ACSM) provides certification for these individuals. If the health promotion program is built around a fitness facility, the program should be headed by a fitness professional; if it does not, the program should be headed by a person trained in health education.

Employee volunteers might manage smaller programs as part of his or her job duties, with services provided through contractual arrangements with community professionals, or by utilizing volunteers from the worksites or community. In smaller programs, the advisory committee could spearhead the program, with members being selected based upon the services needed by the program, for example, graphic design, marketing, data processing, accounting, and training.

The sequence of program activities is determined through needs assessment, planning, implementation, and evaluation (Simons-Morton, et al., 1995). Surveys and focus groups could be used to indicate employee interest and needs. A program mix could be developed based on the findings and the resources available. Topics to be covered and the level of intensity of the programming for each area could be included. Business events could be coordinated with national campaigns, i.e., National Heart Month, and the Great American Spoke-out. A program calendar of events would be laid out and responsibilities for promoting, conducting and evaluation of the events assigned. A health promotion program alone cannot accomplish the objective for the worksite as addressed in *Healthy People 2000*. A worksite health promotion program must be coordinated with other programs within the company or joined with community resources.

Employee Assistance Programs (EAP) are often combined with worksite health promotion programming to assist employees with personal needs. Employee Assistance Programs within the company no longer focus only on alcohol and drug problems, they often provide short-term counseling and referral to community organizations for family, financial, and work related problems. Occupational safety and health programs within corporations are responsible for monitoring and controlling environmental hazards, training worker's in safety practices, and informing them of risks they may encounter in their work (Simons-Morton, et al., 1995). Business is constantly involved in adapting the workplace to the needs of the individual and the task to be done.

Coordination among these programs is necessary if providing individual employee centered service is a priority. Programs can provide easy referral of employees from one program to another, while providing comprehensive programming to ensure that

prevention, screening, and treatment are available and that both environmental and individual approaches to risk reduction are used. Unfortunately, within an organization these programs could be competing for the same scarce resources. Different groups could become territorial, thus, reducing the ability to cooperatively work at providing a comprehensive program for the employees. It has been shown that in the best interest of the company and employee that these cooperative efforts are made. Success can be found by creating a cross functional team where members from these programs work within a single unit of the organization, such as human resources.

Future Trends

Worksite health promotion programs have experienced incredible growth over the past 15 years. The scope and breadth of these programs will likely continue as companies struggle to provide quality, yet, economically sound benefit packages. The increasing cost of employee health benefits will lead to new trends in the options and alternatives available to employers as they work to manage and stabilize employee health benefit costs.

Chapman (1996a) listed 28 future trends affecting employer provided benefits, some of those specific to health promotion are listed below:

1. A growing movement toward self-insurance and more aggressive application of risk management approaches.
2. A growing recognition of the need to strengthen consumer and provider incentives in shaping health care use behavior and patterns.

3. Increased awareness of the importance of employee communications and its role in influencing benefit and health care use choices.
4. Increased movement to self-administer health plan coverage.
5. A continuing movement toward greater employee choice among benefit options and alternatives (i.e. flexible benefit plans).
6. A continuing need to tailor employee benefit programs to address an increasingly heterogeneous workforce.
7. More active efforts to “risk-rate” employee health benefit coverage.
8. More active experimentation with financial incentives around health care use and reduction of the prevalence of major health risks.
9. A growing trend to shift first dollar cost sharing to employees within the design of health benefit programs.
10. A continuing demand for activities which decrease requirements and demands on the administrative time of human resource staff.
11. Increasing demand for “user-friendly” employee benefit products and services (pp. 28-29).

According to Chapman (1996a), the cumulative effects of these trends has caused significant change in the structure and practices that guide the employee benefits field.

The U.S. workforce has changed. The population has gotten older, and is becoming more diverse in terms of race and ethnicity. Although growth has slowed, from 1980 to 1991 the proportion of people 65 years or older increased from 11.3% to 12.6%, increasing the size of this age group by approximately five million to more than 30 million (U.S. Bureau of Census, 1992). One obvious reason for this aging of the population is

better health that fosters increased longevity. The second major demographic change that organizations are experiencing is an increase in racial and ethnic diversity, resulting from both the generally higher birth rates that exist among minority groups and the changing pattern of immigration in the United States (Simons-Morton, et al., 1995). Each of these demographic shifts has created unique challenges for companies in meeting the needs of their employees. As diversity becomes commonplace, the workforce of the future will demand programs that are individualized for each subpopulation. Program scope and breadth will need to address their special needs, incorporating strategies that are sensitive to cultural and age differences.

Just as the demographics of the working population has changed, organizations have begun to reflect these changes. Everyone's life includes some degree of health risk. Lifestyle risk pushes a person in a danger zone when they include certain unhealthy activities, a danger that lurks not only for the individual but for the employer as well. Worksite health promotion programs need to continue to involve the high-risk employee and focus programming on underserved populations. It has been shown that high-risk employees cost more than low-risk employees because they are less productive, are absent more, submit more and larger health claims, and spend more time in the hospital (Rosen & Berger, 1991).

Many organizations have large numbers of employees who spend their time off-site. Those who work off-site are typically isolated from health promotion efforts offered only at the workplace. These workers not only lack access to programs, but must cope with the difficulties of maintaining good health habits alone. Health promotion programs

must address the health needs of these workers and/or develop effective ways of reaching them.

The survival and growth of worksite health promotion programs in the future will come from employee involvement. Modern management experts have placed continued emphasis on “improving quality of service and products and involving employees in management (participatory management)” (DeJoy & Wilson, 1995, p. 244). Both of these targeted areas could provide a strong base for employee-driven health promotion programs. When employees are given the power by management to improve the work environment and culture, effective strategies will emerge to create a more healthy organization.

The values of the 21st Century workforce could be different from those of the 20th Century and the Industrial Revolution. Yankelovich (1983) has identified a new set of values, “expressive values” characterized by the escalating interest in well-being and quality of life, not only for oneself but for family members as well. With this set of values, employees would be inclined to seek family-focused health promotion programs. These family programs would likely emerge as important tools in recruiting and retaining qualified employees (DeJoy & Wilson, 1995). For decades, managers did not perceive employees’ health as their business. Illness was regarded as a single and personal event separate from work. An organization’s role was limited to paying health premiums, typically through a third-party insurance company. Today the picture is much different. With health costs skyrocketing, organizations are making major shifts in their thinking, moving away from treating costly illness to preventing problems before they happen. In

other words, organizational interests are increasingly moving from prescriptive to preventative medicine (Rosen & Berger, 1991).

STRATEGIC LEADERSHIP

Background

In general, the term “leadership” has meant different things to different people. An individual’s perspective, along with the aspect(s) of the phenomenon that are of interest to him or her, has been used most frequently to define leadership at the personal level.

Stogdill (1974), in a comprehensive review of leadership literature, has concluded that there are nearly as many definitions of leadership as there are persons attempting to define it. Nahavandi (1997), after examining many definitions of leadership, has concluded that the various definitions have the following characteristics in common: First, leadership is a group phenomenon; there are no leaders without followers. Leadership involves interpersonal influence. Second, leadership is goal-oriented. Leaders use interpersonal influence to guide groups toward the achievement of certain goals. Third, the presence of leaders often assumes some form of hierarchical relationship. When these three elements are present, Nahavandi has defined a leader as “any person who influences individuals and groups within an organization, helps them in the establishment of goals, and guides them toward achievement of those goals, thereby allowing them to be effective” (p. 4).

Effectiveness, then, has been given almost as many differing definitions as leadership, with its definition stemming from a particular focus such as group

performance, followers' satisfaction, or implementation of change. The choice of a definition depends on the point of view of the person trying to determine effectiveness, and on the constituents being considered. Research indicates that bosses and subordinates have differing ways of defining effectiveness (Casteneda & Nahavandi, 1991). The most commonly used measure of leader effectiveness is the extent to which the leader's organizational unit performs its task successfully and attains its goals (Yukl, 1994).

It is rarely possible to evaluate all the different roles and functions that a leader performs. A definition of effectiveness that takes into account both process and outcome is proposed by Nahavandi (1997). She suggests that a leader be considered effective when his/her group is successful in maintaining internal stability and external adaptability while achieving its goals.

There has been considerable research and controversy surrounding the differences between leadership and management. Clearly, a person can be a leader while being a manager, and a person can be a manager without being a leader. Bennis and Nanus (1985) have suggested that "managers do the right thing and leaders do things right." Many researchers have suggested that leaders are oriented toward change and innovation, while managers are oriented toward stability and short-term perspectives (Beckon, 1998; Bennis, 1989; Gardner, 1986; Yukl, 1994).

Luthans (1988) distinguished between successful and effective managers. An effective manager is said to be one who has satisfied and productive employees, whereas successful managers are those who are promoted quickly. Luthans found that effective managers spend their time communicating with employees, managing conflict, training, developing, and motivating employees. Those said to be successful managers focused on

networking, which involved politicking, socializing, and interacting with outsiders. The study of leadership has been approached using a variety of concepts. When reviewing leaders who seem to have a profound effect on their organizations, often, those leaders are discussed in terms of charismatic, transformational, or visionary.

Leadership Characteristics and Future Planning

Literature in the field of leadership is replete with notions about the characteristics of leaders and their ability to envision and plan for the future. According to House (1977), charismatic leaders are those who have a profound emotional affect on their followers. They may be perceived as role models and heroes that are larger than life. Charisma occurs most often during times of social crisis or when one is imminent. The leader emerges as the one with exceptional personal qualities that provide a solution to the crisis, and the leader attracts followers who believe in the vision and perceive the leader to be extraordinary (Trice & Beyer, 1993). Charismatic leaders are likely to display a high degree of self-confidence, creating an impression among followers that the leader is competent. Further, charismatic leaders hold a strong conviction about the correctness of their ideas. The mission or goal(s) are communicated and articulated with a high level of enthusiasm and excitement. Language, imagery, and symbols are all used by the charismatic leader to motivate and appeal to the emotions of the followers. Charismatic leaders are likely to set examples for their followers to imitate. They serve as role models for the beliefs and values that they expect the followers to emulate (Nahavandi, 1997; Yukl, 1994).

Building commitment to organizational goals and empowering followers to accomplish these goals is at the heart of transformational leadership (Yukl, 1994). Burns (1978) was the first to distinguish transformational from transactional leadership, contending that transactional leadership focused on basic and largely extrinsic motives and needs. In contrast, transformational leadership is focused on higher-order, more intrinsic, and ultimately moral motives and needs. These leaders should meet the needs of the followers, and should elevate followers to a higher moral level. A truly transformational leader is one whose innovations are so deeply ingrained that there is a legacy resulting from his or her leadership (Evans, 1997).

In addition to the concepts surrounding charismatic and transformational leadership, numerous change-oriented views of leadership have been developed. Change-oriented leadership appears to focus on providing a vision and showing confidence in the followers' abilities in order to transform organizations. Bennis and Nanus (1985) focused on the need for the leader to demonstrate exceptional behaviors. Conger and Kanungo (1987) focused their studies on empowerment and the setting of examples of risktaking and competence. Shamir (1991) addressed the need for setting challenging goals and a show of personal consideration.

Kouzes and Posner (1995) have developed one of the most clearly defined models of visionary leadership. Their model of exemplary leadership incorporates five practices including: (a) Challenging the process, searching out opportunities and experimenting; (b) Creating a shared vision where there is a future focus and an inclusion of the followers' vision; (c) Enabling followers to implement vision through collaboration and empowerment; (d) Role modeling and recognizing small successes; and (e) Encouraging

the heart through enthusiasm and contingent frequent feedback. Along with presenting exemplary leadership practices, they have considered the point of view and expectations followers' have of leaders (1993). Exemplary and visionary leaders commit themselves to questioning old beliefs and assumptions. Through empowerment, encouragement, and proper role modeling, leaders can motivate followers to implement the vision (Nahavandi, 1997). Credibility is the driving force behind a leader's ability to fulfill this commitment. Kouzes and Posner (1993) identified honesty, the ability to be forward-looking, and the capacity to be inspiring and competent as the mainstay of a leader's credibility. The ability to change the organization and the followers depends upon the leader's credibility.

Change has many forms: some familiar, some strange, some attractive, some not; some large, and some small. Regardless of the form it takes, constant change in the workplace has become inevitable and, seems to be the norm. Companies and people must change if they are to "grow healthier and more productive. So for the manager -- and really for all working people -- the critical issue becomes not just identifying the nature of change but, more importantly, learning how to manage its impact" (Rosen & Berger, 1991, p. 98). Change-oriented theories will need to expand, in an effort to identify those situations under which each type of leadership would be more appropriate and effective.

Upper-Echelon Leaders

Nahavandi (1997) distinguished between micro and upper-echelon leaders. Micro leadership is concerned with small groups or small departments, with upper-echelon leaders having jurisdiction over entire organizations. Upper-echelon leaders have

discretion and power over many decisions. The focus for micro leaders is generally internal to the organization. They may be involved with external constituents; however, they do not need an external view in order to perform their job. In contrast, the upper-echelon leader requires an almost equal attention to internal and external factors.

Effective micro leaders focus on department productivity, quality of products and services, and employee morale. The upper-echelon leader considers overall organizational performance, stock prices, and satisfaction of outside constituents. The overall effectiveness may be on company growth and return on investment.

In addition to dealing with outside constituents, upper-echelon leaders are responsible for the formulation and implementation of the strategy of their organization. As a result, much of the research has been done on the link between leadership and strategy. Overall, the strategy of an organization is how it achieves its vision, mission, and goals (Nahavandi, 1997). Bennis (1984) found that compelling vision is the key ingredient of leadership among heads of the highly successful organizations he studied. Vision refers to the ability to create and communicate a view of a desired state of affairs that induces commitment among those working within the organization. Wheatley (1992) described vision as the need for organizational clarity about purpose and direction. If vision is important for the organization, it must be important for the individual. By focusing on a vision, leaders can lead their organization through periods of chaos.

Strategy consists of an integrated, cohesive plan for achieving an organizations short-term and long-term objectives (Quinn, 1980). For decisions involving major changes in organizational strategies or policies, the outcome will depend on the influence skills and persistence of the individual managers who desire the change (Kanter, 1982;

Kotter, 1982, 1985). Strategy provides an organization with guidelines for decision making. According to Malekzadeh (1995), when managing organizations, leaders need to juggle six factors, keeping an eye on all of them at the same time. These six factors include: technology, structure, strategy, culture, environment and leadership. Culture is defined as a common set of beliefs, values and assumptions shared by members of an organization (Schein, 1985). Structure is comprised of the basic design dimensions that organize the human resources of an organization (Pugh, Hickson, Hinings and Turner, 1968). The environment includes all outside forces that may potentially affect the organization and, finally, technology is the process by which inputs are transformed into outputs (Nahavandi, 1997). Any strategic effort requires a balance and fit among these six, which is the essence of strategic management (Malekzadeh, 1995).

For the upper-echelon leader to decide the direction of the organization, a balance of these factors is necessary. Once a direction is decided, internal forces (for example, culture, structure and leadership) come into play in order to move the organization toward the selected path (Nahavandi, 1997). Upper-echelon leadership characteristics have been studied using demographic and psychological variables. After looking at these differing perspectives, Nahavandi and Malekzadeh (1993) identified two common themes.

The first theme has to do with the degree to which an individual seeks challenge and is a risk taker. Nahavandi and Malekzadeh (1993) ascertain that the more challenge-seeking person is more likely to engage in risky strategies and to undertake new and original endeavors; while a person who is not high on this dimension will be reluctant to take risk and will stick with well established and proven methods. Nahavandi (1997) identifies challenge seeking as the most relevant way a leader formulates strategy. A

challenge seeker who is at the helm of an organization is likely to be willing to change the strategic direction of that organization. A challenge-averse leader will stick to the existing path.

The second theme identified by Nahavandi and Malekzadeh (1993) is the leaders need for control. This theme refers to how willing the leader is to delegate, or give up control, allowing others to participate in decision making and implementation of strategy. The leader with the high need for control is likely to create an organization with low delegation and low focus on process. The culture will be tight and focus will be on uniformity and conformity, whereas, the manager with a low need for control will likely decentralize the organization and delegate many of the decision-making responsibilities (Nahavandi & Malekzadeh, 1993; Nahavandi, 1997). A leader with a low need for control is likely to encourage a culture that is open and adaptable with a focus on integration of various ideas. This type of organizational culture is likely to encourage employee involvement and tolerance for diversity of thought and style (Nahavandi & Malekezdal, 1993).

Nahavandi's Strategic Leadership Theory and Model

Nahavandi and Malekzadeh (1993) have developed two themes as the major dimensions of strategic leadership. These dimensions impact the leader's decision-making and managerial styles, as well as the way he or she manages strategic forces. The leader must first understand and interpret the environment of the organization. Secondly, as the decision-maker, the leader selects the primary strategy for the organization. Third, the

leader is critical to the implementation of the chosen strategy through the creation and encouragement of a certain culture and structure, as well as the selection of leaders and managers throughout the organization.

The two dimensions of challenge-seeking and need for control are combined to yield four strategic leadership types (Nahavandi, 1997). Each type will handle the strategic forces in a manner consistent with his or her basic tendencies and preferences (Table 2.1). The leader not only defines and influences strategic forces, according to Nahavandi (1997), his or her style also needs to be matched to existing ones.

Table 2.1		
Strategic Leadership Dimensions		
Challenge-Seeking	High Challenge-Seeking	
	High Control Innovator (HCI)	Participative Innovator (PI)
	Challenge-seeking leader who maintains tight control of his/her organization	Challenge-seeking leader who delegates control of his/her organization
Challenge-Seeking		
	Status-Quo Guardian (SQG)	Process Manager (PM)
	Challenge-averse leader who maintains tight control of his/her organization	Challenge-averse leader who delegates control of his/her organization
Low Challenge-Seeking		
	Low Challenge-Seeking	
	High control	Low control
Desire For Control		
Nahavandi & Malekzadeh (1993)		

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Each type of strategic leader is likely to create a particular type of organization that would

ideally fit into a certain environment (Table 2.2). Nahavandi's first type of strategic leadership is High-Control Innovation, (HCI). HCI leaders are challenge seekers who like to maintain tight control over the functions of the organization. These leaders look for innovative and risky strategies; they are likely to navigate uncharted waters and enter new markets, or even new industries (Nahavandi, 1997). The High-Control Innovator is focused on new strategic approaches to the future of their organization (Nahavandi & Malekzadeh, 1993).

Table 2.2 The Impact of Leadership Types on Strategic Forces			
Source: Nahavandi and Malekzadeh (1993)			
Leader	Strategy	Culture	Structure
HCI	High-risk strategies Product Innovation Stick to core business	Strong dominant culture, few subcultures	Centralized decision making by a few people
SQG	Low-risk strategies Few innovation Focus on efficiency	Strong dominant culture low tolerance for diversity	Centralized decision making by a few people
PI	High-risk strategies Product innovation Open to new areas	Fluid main culture Many cultures High tolerance for diversity	Decentralized decision to lowest levels Empowerment and participation
PM	Low-risk strategies Few innovations Focus on efficiency	Fluid culture with focus on "no change" Tolerance for diversity	Decentralized decisions Participation

Nahavandi & Malekzadeh (1993)

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The HCI is very interested in innovation when it comes to external factors but, tends to be conservative in the management of his or her organization. A need for control may create a controlled culture where adherence to common goals and procedures are encouraged and rewarded. Decision-making is likely to be centralized with little

delegation of decision making. The High-Control Innovator encourages risk taking with regard to outside factors, but discourages departure from the organizations accepted internal operations (Nahavandi, 1997).

Like the High-Control Innovator the Status Quo Guardian (SQG) likes to maintain control. However, they do not seek challenge. This type of leader needs to maintain control over the internal functions of the organization and is risk averse. The SQG does not seek new and innovative strategies. Strategic decisions will be made in an effort to keep the organization close to where it has been successful in the past. Organizations led by Status Quo Guardians will not be known for new innovations, but will likely be known for efficiency. The ideal organizations for a SQG will be highly focused and conservative. Their culture will be well defined and expect employees and managers to conform to existing procedures and practices. Decision making will be centralized with the Status Quo Guardian leader involved in the majority of decisions (Nahavandi, 1997).

Diametrically opposed to the SQG is the Participative Innovator (PI). Unlike the Status Quo Guardian, Participative Innovator seeks challenge and innovation on the outside, and creates a loose, participative, and open culture and structure inside the organization. Like the HCI, the PI seeks challenge and is likely to select high risk strategies. According to Nahavandi (1997), organizations led by a Participative Innovator are likely to be known for being on the cutting edge of technology, management innovation, and creativity. An open and decentralized organization is ideal for the PI with decisions being made at the lowest possible level. The culture is likely to be loose with high tolerance for diversity of thought and practice. Participative Innovators will likely

encourage employees to create their own procedures and allow them to implement their decisions (Nahavandi, 1997).

The last type of strategic leader prefers conservative strategies that stick to the tried and tested. The Process Manager (PM) is likely to shy away from risky innovation. However, the low need for control allows for diversity and openness within the organization. Employees are not required to adhere to common goals and culture. A great deal of autonomy is allowed with day-to-day operations not highly standardized. Flexibility exists in the way things are managed, focusing on not creating undue risk for the organization (Nahavandi, 1997).

These four types of strategic leaders have a different preference for the direction and management of their organization. Each asserts their influence in a number of ways. First, a leader shapes and influences his or her organization. Second, the top executive is often the one who has the final say on allocation of resources. Reward systems, both formal and informal have a powerful impact on the culture of an organization (Schein, 1985). Another way leaders have tremendous impact on their organization is through the selection of other leaders and the promotion of those who adhere to the leader's culture.

Indirect ways of impacting an organization are influenced by the types of behavior the leader models (Nahavandi & Malekzadeh, 1993; Schein, 1985). Even dress, fitness habits, or style of interaction have been deemed symbolic means through which a leader indirectly influences an organizations culture. Conversely, allocation of resources, rewards and modeling are some ways in which a leader directly impacts his or her organizational culture. Therefore, it is through these indirect and direct behaviors and/or activities that a leader impacts an organization (Nahavandi, 1997).

Health behavior is influenced by many complex forces, including family, role models, social pressures, advertising, and environment. Today, health is perceived as a matter of wellness, having a sense of vitality and overall well-being in life. Health in the workplace extends far beyond questions about employee sick days and insurance coverage. Health concerns are reflected in every aspect of an employee's working life. Lifestyle disease represents the major threat to health and quality of life among Americans. To reach the desirable goals of improved health in the workplace and health care cost containment, the depth and breadth of a health promotion program must appeal to and reach as many employees as possible.

With the U.S. workforce changing so dramatically, leaders in the areas of health promotion and wellness have a unique opportunity to impact the health and the quality of life of their employees. Leadership has been defined in many different ways over the years. However, leaders are often viewed as any person who influences individuals and groups within an organization, helps them establish goals, and guides them toward achieving those goals. For change to occur, knowledge alone is insufficient. Attitudes and beliefs are catalysts of behavior change because the more highly a health benefit is valued, the greater the chance of making a change and adhering to it (Anspaugh, et al., 1997). Worksite health promotion programs help companies contain health expenditures as well as, retain and recruit quality employees. Providing a comprehensive employee benefits package, including health and wellness activities, may be the deciding factor used by the next generation of workers to determining which organization they choose to commit themselves to.

CHAPTER THREE

METHODS AND PROCEDURES

Health promotion and wellness programs are commonly used to offset the increasing costs of employee health care. Although the scope and breadth of programming varies, these wellness programs have been proven to decrease overall costs, reduce absenteeism, and increase employee morale; while educating employee's about behavioral or lifestyle changes that can improve the quality of their lives. To date, no research has been conducted that examines the strategic leadership styles of directors of university/college employee wellness or health promotion programs. It is imperative that organizations begin to look at strategic leadership tendencies and there impact on future programming.

Research Design

The study used a mixed-methodology design that takes advantage of quantitative and qualitative approaches for the purposes of triangulation and expansion of findings. Specifically, this research was quantitative dominant, with post hoc interviews constituting a qualitative follow-up treatment. Phase I was descriptive research, wherein scores from two Likert scale instruments were compared. Phase II utilized a grounded theory approach via open-ended questions.

Population and Sample

The population for this study consisted of those people who were directing an employee wellness program at four-year colleges or universities. For Phase I, a random sample of 50 wellness directors was drawn from the *1998-2000 NWIRC Directory: Wellness in Higher Education*. For phase II, the sample consisted of eight directors who volunteered to participate in post hoc interviews.

This sample was selected for the following reasons. First, the *NWIRC Directory: Wellness in Higher Education* lists summaries of two- and four-year colleges and universities offering wellness or health promotion programs. It was the only association specific to institutions of higher education. Second, as members, these directors receive such organizational benefits as academic and professional publications, database information, and research information on the most current status of wellness and health promotion. Finally, the sample was limited to top-level directors, thereby reaching only the upper-echelon leaders of wellness organizations. As discussed in Chapter Two, these administrators are uniquely positioned for organizational oversight. They are the decision-makers whose understanding of their organizations' structure and culture - coupled with their strategic leadership attributes - have the greatest impact on their organization.

Procedures

From a roster of all four-year colleges and universities listed in the *1998-2000 NWIRC Directory: Wellness in Higher Education*, 50 directors were randomly selected.

A single survey questionnaire along with a stamped return envelope was mailed to each of the 50 university/college employee wellness directors. Approximately two weeks after the initial mailing, a postcard reminder encouraging directors to complete the survey was mailed. Approximately three weeks later, a letter and replacement survey was sent to those directors who had not returned the survey. Two weeks after the replacement survey was sent, the questionnaire was tabulated. The names and phone numbers of respondents volunteering to participate in the interview process were contacted and their comments recorded and coded to be used in the qualitative portion of the study. Upon completion of the data analysis (both quantitative and qualitative), a brief summary of the findings was written and sent to all participants.

Instrumentation

The primary instrument for gathering both quantitative and qualitative data was a questionnaire with four parts (See Appendix B). Part A requests demographic information about the subjects' educational background and experience, as well as scope and breadth information about the programming of the university/college employee wellness organizations that they direct. Part B used Likert-style responses about the individuals' organization. For this section, the "organization" was defined as the university/college wellness program the respondent directs. This information was used to determine the type of organizational structure and culture that existed in their university/college employee wellness programs. Part C also used Likert-style responses to several statements devoted to leadership and future planning for wellness or health

promotion. Some qualitative data was also gleaned from this section, as participants made individual comments in response to the statements. Part D of the questionnaire was designed to elicit data for determining the individual's strategic leadership type. From this section, two scores were established. The first was a challenge-seeking score, and the second was determining the director's need for control. Scores from Part B and Part D were placed on a scoring grid (Appendix C), and this grid was used to determine the strategic leadership type the respondent most closely aligned himself or herself with.

Parts B and D of the survey instrument were developed by Dr. Afsaneh Nahavandi in 1997 to investigate strategic leadership types. As a newly minted instrument, it is currently being utilized in several studies which will test and further expand awareness of its validity. Part B, *Your Organization*, and Part D, *What is Your Strategic Leadership Type* have been employed regularly at Arizona State University-West to examine business administration students' strategic leadership styles. There, Dr. Afsaneh Nahavandi has been assessing its concurrent validity against successful business managers. Preliminary data from these uses has indicated a positive correlation between her model and business leader types.

Assumptions and Rationale for Phase II

For Phase II of the study, a qualitative research approach was selected as the most feasible way of gaining information from wellness directors currently directing health promotion/wellness programs at public four-year colleges and universities. Furthermore, a grounded theory inductively derived from the study of strategic leadership, designed by

Nahavandi (1997), was used. Nahavandis' grounded theory allows for data collection, analysis, and theory to stand in reciprocal relationship with each other (Strauss & Corbin, 1990). The theory was validated through systematic data collection and analysis of data pertaining to strategic leadership styles used by directors in university wellness/health promotion programs. The following assumptions were used:

- Reality is subjective and multiple as seen by participants in the study.
- The researcher will be the primary instrument for data collection.
- The researcher will interact with those being researched.
- The research will be descriptive in that the researcher is interested in process, meaning and understanding gained through words and stories.
- Information gained may be value-laden and biased.
- An emerging design using categories identified during the research process will be used.
- An inductive process will be used to build concepts, hypotheses, and theories from details.

Grounded theory was originally developed by two sociologists: Barney Glasser and Anselm Strauss. They worked together to develop the technique for analyzing qualitative data. Each man brought a distinctive philosophical and research background to the development. Strauss' strong qualitative research background contributed, among other things, the following: a) the need to get out into the field, in order to understand what is going on; b) the importance of theory, grounded in reality; c) the nature of experience and undergoing as continually evolving; d) the active role of people in shaping complexity of life; and f) the interrelationships among conditions, meaning, and action

(Strauss & Corbin, 1990, pp. 24-25). Glasser was steeped in the tradition of quantitative methodology. He saw the need for well thought out, explicitly formulated, and systematic procedures for both coding and testing hypotheses generated during the research process (Strauss & Corbin, 1990).

Although grounded theory was developed by sociologists, it has been used successfully by people from many disciplines. The procedures are not discipline bound, as each investigator is interested in different phenomena, or many view the same phenomena differently. Concepts are the basic building blocks of theory. One begins by asking questions about concepts (strategic leadership styles). Questions will help to describe what is happening, to form hypotheses, and suggest how these concepts might possibly relate to each other. Hypotheses permit deductions, which help to guide data collection, leading to further induction and provisional testing of hypotheses.

Item Development

Demographic and wellness portions were added to the Nahavandi instrument for the purposes of this dissertation. Section C of the questionnaire listed 11 statements pertaining to health promotion and future planning. Items were selected based on the emergence of future planning issues gleaned from the literature. To gain a wellness and/or health promotion perspective on the strategic leadership style of the directors, it was necessary to include some wellness-based questions. Appendix E details the specific research examined in development of the statements.

Treatment of the Quantitative Data: Phase I

Data from Parts A, B, C, and D of the instrument were analyzed with consideration for a variety of variables. Specifically, the data was reported using descriptive analysis along with frequency distributions and through the utilization of the Mann-Whitney U Test, Chi Square, and a two-tailed t-test. Statistical significance was declared at $p \leq .05$. Demographic data from Part A and the combined scores from Parts B and D (establishing the type of strategic leader) were used as categorical variables serving as the basis for subsequent analyses.

Treatment of the Qualitative Data: Phase II

Consistent with grounded theory methodology, interview data were categorized and analyzed thematically. An interview protocol included the following components: a) a heading; b) opening statements; c) key research questions that are to be asked; d) probes to follow key questions; e) space for recording comments; and f) space for the researcher to record reflective notes (Creswell, 1994). Information from the interviews was recorded through note taking. Following coding, the researcher sought member checks for further follow-up quality control purposes.

The Role of the Researcher in Phase II

As with any qualitative research project, the researcher interpreted the data. Each

researcher brings biases, values, assumptions, ways of thinking, and knowledge gained through experience and reading to the analysis. Using various coding techniques in some ways diminished these biases, but can in no way eliminate all.

Although the researcher has no significant past experience doing qualitative research, her background in the health promotion field assisted in an understanding of the data. The researcher has directed and is familiar with the college/university wellness program. University wellness directors were selected due to their understanding of the need for research at institutions of higher education.

For Phase I, initial contact was made by mail with selected directors. Those respondents who volunteered for inclusion into the interview pool were asked to give examples related to the scope, breadth, mission, and future planning of their wellness organizations. Phone interviews were scheduled and conducted. Every effort was made to accommodate the director's schedule. Interviews were coded (using open, axial and selective methods). Throughout the interview, fieldnotes were taken in an effort to direct questions, and establish categories.

Some areas of the leadership process may be seen as sensitive. Although stories and quotes from wellness directors have been used, the anonymity of the directors was preserved. The research was used solely to better understand the strategic leadership styles exhibited by those directors selected.

CHAPTER FOUR

RESULTS

Introduction

The primary purpose of this study was to investigate strategic leadership theory as applied to directors of university/college wellness programs. A sample of 50 directors was randomly selected from among the 196 public four year colleges and universities listed as providing faculty/staff wellness in *The 1998-2000 National Wellness Information Resource Center Directory: Wellness In Higher Education*. The subjects were responsible for university/college wellness or health promotion programs and were requested to provide data in the form of survey responses, which helped to answer the following questions:

- What types of strategic leaders are found in university/college wellness/health promotion programs?
- How is strategic leadership related to the programming and future planning of the university/college wellness/health promotion program?
- Is the type of organizational structure of the university wellness/health promotion program associated with the leader's strategic leadership style?
- Is the organizational culture of the university wellness/health promotion program related to the leader's strategic leadership style?
- What is the nature of the future planning process implemented by different types of strategic leaders?

Thirty-two university or college wellness directors returned surveys for a response rate of 64%. These respondents provided the data for the quantitative analyses and served as the group from whom interviews were conducted for the post-hoc qualitative analysis. This chapter describes the sample and provides the complete analysis of the data.

Characteristics of the Sample

Responses to Part A of the survey instrument provided a profile of the sample's demographics: each director's total years of experience as a director in wellness or health promotion, experience at their current position, level of education, and field of education. Part A also solicited information about their institutions of employment, including the number of employees, approximate number of employees currently using health promotion/wellness programs, whether or not spouses or dependents were allowed to participate in wellness programming, whether or not there was a fee assessed for spouses or dependents to use these services, yearly operating budget, and whether or not the wellness/health promotion program had established and utilized an employee wellness advisory board.

Demographic Profile: University/College Wellness Directors

Directors of university wellness/health promotion programs indicated their total years of experience in the field as presented in Table 4.1. This table demonstrates that the

range of experience varied from less than one year to more than 20 years as recorded in whole years. There were 19 directors (59%) who had between one and six years of experience in the field, while 13 directors (41%) had from eight to twenty years of

Table 4.1

Directors of University/College Wellness Programs Total Years of Experience (n=32)

Years of Experience	Absolute Frequency	Relative Frequency
1 or less	7	21.8%
2	1	3.1%
4	5	15.6%
5	3	9.4%
6	3	9.4%
8	2	6.3%
9	3	9.4%
10	1	3.1%
12	2	6.3%
13	1	3.1%
15	2	6.3%
16	1	3.1%
20	1	3.1%
Total	32	100%

experience as a director of wellness or health promotion. Seventy-five percent of the directors had four or more years of experience. The mean number of years of experience of all the directors of wellness or health promotion in this study was 6.8 years in the field.

Additionally, these university wellness directors indicated that their experience at their current institutions ranged from 10 months to 20 years, 6 months, as shown in Table 4.2. Directors have held their current positions for a mean of 6.9 years. Fifty-nine percent of the directors had four or more years experience at their current institutions. while 28% had one year or less at their current institutions.

Table 4.2

Wellness Directors' Experience at their Current Institutions (n=32)

Experience Category	Absolute Frequency	Relative Frequency
One year or less	9	28.1%
1 to 3 years	2	6.3%
3 to 5 years	4	12.5%
5 to 8 years	5	15.6%
8 to 12 years	6	18.7%
12 to 16 years	4	12.5%
More than 16 years	2	6.3%
Total	32	100%

The frequency distributions of university wellness directors' levels of education are displayed in Table 4.3. All directors provided responses in the general information

section of this survey seeking to determine their levels of education. and the results were that four directors (13%) had completed Bachelor's Degrees. 19 directors (59%) had earned Master's Degrees, and 9 (28%) held terminal or Doctoral Degrees. Of those completing Master's Degrees, six were in the area of Exercise Physiology/Exercise Science; four were in Physical Education or Health and Physical Education; three were in Community Health or Health Education; and six were in a variety of areas, including Health Promotion, Counseling, and Hospital and Health Administration. Of those nine directors completing Doctoral Degrees, four were in Kinesiology/Exercise Physiology/Exercise; two were in Health Education; two were in Urban Health Services/Health Services; and one was in Nutrition.

Table 4.3

University Wellness Directors' Levels of Education (n=32)

Level of Education	Absolute Frequency	Relative Frequency
Bachelor's Degree	4	12.5%
Master's Degree	19	59.4%
Doctoral Degree	9	28.1%
Total	32	100%

Table 4.4 indicates the gender of those directors responding to this survey. Of those responding to this question, the results show that 21 directors, or 66% of this group were female, and 11 or 34% of the directors were male.

Table 4.4

University Wellness Directors Gender (n=32)

Gender	Absolute Frequency	Relative Frequency
Male	11	34%
Female	21	66%
Total	32	100%

Demographic Profile: Institutional Information

Table 4.5 outlines the number of full-time employees currently working at the

Table 4.5

Number of Full-Time Employees at Current Institution (n=26)

Number of Full-Time Employees	Absolute Frequency	Relative Frequency
Below 1000 full-time employees	10	38.5%
1000 to 2000 full-time employees	4	15.4%
2000 to 3000 full-time employees	4	15.4%
3000 to 4000 full-time employees	3	11.5%
4000 to 5000 full-time employees	1	3.8%
More than 5000 full-time employees	4	15.4%
Total	26	100%

institution at which the respondent serves as the director of employee wellness. After eliminating invalid responses, 26 entries were suitable for tabulation. Thirty-nine percent of those responding reported fewer than 1000 full-time employees, while 15%, or four institutions, reported between 2000 and 3000 full-time employees. Numbers of full-time employees ranged from 40 to 14,000.

Only 18 (56%) of the survey participants responded when asked how many part-time employees worked at their institution. The frequency distributions reported in Table 4.6 indicate that 11 directors (61%) reported that their institution had 500 or fewer part-time employees, while 5 (28%) indicated that they had 1000 or more part-time employees. The number of part-time employees reported ranged from 50 to 3000.

Table 4.6

Number of Part-Time Employees at Current Institution (n=18)

Number of Part-Time Employees	Absolute Frequency	Relative Frequency
500 or fewer part-time employees	11	61.1%
500 to 1000 part-time employees	2	11.1%
1000 or part-time employees	5	27.8%
Total	18	100%

When asked to estimate the number of people using their programs, directors reported a range of 11 to 7000 employees. Thirty-six percent of the directors (11) reported between 100 to 1000 employees using employee wellness programs, while an

additional 29% (9) revealed that they had 1000 or more employees using university wellness or health promotion services. Of the 31 directors responding to this question, 19% (6) indicated either that they did not know, that it was difficult to estimate because services were offered through several departments, or they offered no response. Employees using health promotion/wellness services are presented in Table 4.7.

Table 4.7

Approximate Number of Employees Using Health Promotion/Wellness Services (n=31)

Number of Employees Using Services	Absolute Frequency	Relative Frequency
100 or fewer employees using services	5	16.1%
100 to 1000 employees using services	11	35.5%
1000 or more employees using services	9	29.0%
Did not know	6	19.4 %
Total	29	100%

Wellness directors' responses to questions regarding whether or not spouses or dependents are allowed to participate in university/college wellness programs are reported in Table 4.8. Eighteen (58%) directors indicated that spouses and dependents are allowed to participate in university wellness programs. One director reported that dependents may participate if they are over 18 years of age. No one other than employees was allowed to participate at 9 (29%) of the universities reporting. Four (13%) of the universities allowed only spouses to participate. However, one respondent

reported that even there for some “family activities” (i.e. skiing), dependents may participate.

Table 4.8

Are Spouses or Dependents Allowed to Participate in Wellness Programs (n=31)

Who May Participate	Absolute Frequency	Relative Frequency
Spouse's only	4	12.9%
Spouse's & Dependents	18	58.1%
No one other than employees	9	29.0%
Total	31	100%

Sixty-seven percent (18) of wellness directors responded that there was a fee for spouses or dependents to participate in university/college wellness programs. Table 4.9 depicts the results of fee assessment. Eight of those directors commented that the fee was

Table 4.9

Spouses/Dependents Assessed a Fee to Participate in Wellness Programs (n=27)

Fee Assessed	Absolute Frequency	Relative Frequency
Yes, there is a fee	18	66.7%
No, there is no fee	9	33.3%
Total	27	100%

assessed only for selected programs, while one reported that the fee was paid through the employees' self-insured health insurance. Thirty-three percent (9) revealed that there was no fee for spouses or dependents to participate. Five directors deemed the question "not applicable."

The tremendous differentiation among university/college wellness budgets is demonstrated in Table 4.10. Twenty-seven directors responded to question Number 9. "What is your yearly operating budget?" with amounts ranging from \$0.00 to \$1,000,000. Three directors did not respond, including one who reported that the budget amount was not made known to him, and one who indicated that s/he operated exclusively from a revenue account. Forty-four percent (12) of the program directors reported having a budget of \$50,000 or less. Only three (11%) reported budgets in excess of \$200,000.

Table 4.10

Yearly Operating Budget (n=27)

Reported Operating Budget	Absolute Frequency	Relative Frequency
\$0.00 to \$5,000	6	22.2%
\$5,001 to \$50,000	6	22.2%
\$50,0001 to \$100,000	6	22.2%
\$100,001 to \$200,000	6	22.2%
\$200,001 or more	3	11.2%
Total	27	100%

Fifty-nine percent (19) of the directors indicated that they have an employee

wellness advisory board. Of those programs with an advisory board, one director referred to his board as a “health safety committee,” and one designated hers as an “ambassador program” used to advise all wellness and recreation services rather than employee wellness exclusively. Forty-one percent (13) do not have an employee wellness advisory board. One director reported that they previously had one, but its charge had been broadened. “Now we have a health management group that oversees both primary and disease management,” she noted. Table 4.11 presents the frequency distributions of wellness advisory board utilization.

Table 4.11

Employee Wellness Advisory Boards (n=32)

Response	Absolute Frequency	Relative Frequency
Wellness Advisory Board Utilization:	19	59.4%
No Board	13	40.6%
Total	32	100%

Demographic Profile: Institutional Programming

The final portion of the general information section of the Strategic Leadership in University/College Wellness Programs questionnaire asked respondents to select from a list the health promotion information or activities currently offered by their employee wellness programs. All the directors responded to the programming section. Table 4.12

demonstrates that all institutions provided blood pressure screening, and that the vast majority of institutions (78%) provided cholesterol screening. The majority of institutions (72%) also use health status questionnaires, yet only 34 percent of the universities offered cancer screenings.

Table 4.12

Health Promotion Offerings by Percent of Institutions (n=32)

Health Promotion Offering	N	%a
Health status questionnaire	23	72%
Blood pressure screening	32	100%
Cholesterol screening	25	78%
Cancer screenings	11	34%

^aPercentages are rounded to the nearest whole number.

Health promotion or wellness programs frequently provide information as well as activities for employees. The various types of information or activities provided, along with the number of institutions offering these services for their employees is summarized in Table 4.13. All 32 institutions provided exercise/fitness activities. 97% provided nutrition information, nearly all programs (94%) provided stress management, and almost one-half (47%) provided job hazards/injury prevention information or activities. Very few (13%) provided information regarding off-the-job accidents, and only 19% offered prenatal education. A variety of other activities and information topics were identified by wellness directors as being a part of their employee wellness programs. Some of these included: "Parenting Our Parents," alternative medicine, retirement planning, therapeutic

Table 4.13

Wellness Information or Activities Offered by Percent of Institutions (n=32)

Information or Activity	N	%a
Blood pressure	29	91%
Mental health	18	56%
Cholesterol	28	88%
Stress management	30	94%
Cancer	22	69%
Alcohol/other drugs	20	63%
Smoking	23	72%
Back care	24	75%
Sexually transmitted diseases	17	53%
Exercise/fitness	32	100%
AIDS education	17	53%
Medical self-care	20	63%
Nutrition	31	97%
Prenatal education	6	19%
Job hazards/injury prevention	15	47%
Weight control	28	88%
Off-the-job accidents	4	13%

^aPercentages are rounded to the nearest whole number.

touch, acupuncture, mindfulness meditation, "Talking to Your Children about Drugs."

self-esteem, eating disorders, "Love and Healing," and "Death and Dying."

Strategic Leadership Type

Nahavandi's Strategic Leadership Model (Part D of the questionnaire) was used to identify the type of strategic leadership displayed by each of the respondents. Four distinct types of strategic leaders were identified using this instrument. Each of the respondents completing the survey was placed into one of the four styles. The styles as identified by Nahavandi (1997) and described at length in Chapter Two are as follows: 1) High-Control Innovator, (HCI), the leader who is a challenge seeker and who likes to maintain tight control over the functions of his or her organization; 2) Status-Quo Guardian, (SQG), the type of leader who likes to maintain control but who also does not seek challenges; 3) Participative Innovator, (PI), the type to seek challenges and innovation, creating a loose, participative, open culture and structure inside the organization; and 4) Process Manager, (PM), the leader who prefers conservative strategies, sticking to the "tried and tested" in practice.

Research Question One

The first question for quantitative analysis was "What types of strategic leaders are found in university/college wellness/health promotion programs?" Table 4.14 shows the frequency of distribution of strategic leader types for university/college wellness directors completing the *Strategic Leadership in University/College Wellness Programs Questionnaire*. Scores were determined by combining the sum of responses to Part D of

the survey. The use of reverse scoring was mandated for five responses, while the other five responses received regular scoring. Responses were combined (using Nahavandi's protocol) to determine both a challenge seeking and need for control score. These scores were then plotted on the scoring grid (Appendix C) that accompanies the instrument. The higher the score the greater the directors' need for challenge or control.

Table 4.14

Strategic Leadership Type (n=32)

Leadership Type	N	%a
High-Control Innovator	8	25%
Status-Quo Guardian	0	0
Participative Innovator	23	72%
Process Manager	1	3%

^aPercentages are rounded to the nearest whole number.

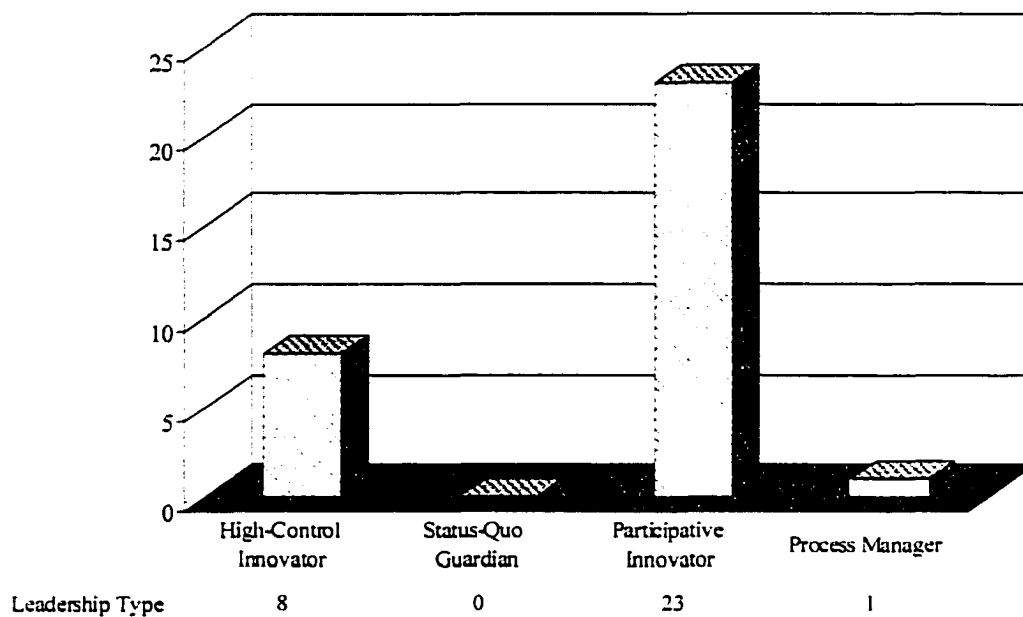
Seventy-two percent of all university wellness directors were categorized as Participative Innovators. Figure 4.1 reveals that no individuals were identified as Status-Quo Guardians, and only one director was categorized as a Process Manager. The remaining 25% (8) were identified as High-Control Innovators.

In determining the specific category of strategic leader for each respondent, subjects were assigned two scores, a *Challenge Seeking* and a *Need for Control* score, calculated through the directors' responses to Part D of the *Strategic Leadership in University/College Wellness Programs Questionnaire*. Both the *Challenge Seeking* and

the *Need for Control* scores have a maximum of 15 possible points, with the higher score

Figure 4.1

Frequency Distribution for Strategic Leadership Types (n=32)



reflecting increasing tendencies to seek more challenges and/or have a greater need for control. Table 4.15 depicts the mean rank scores for all respondents on the *Challenge*

Table 4.15

Challenge Seeking and Need For Control Scores for All Respondents (n=32)

Sub-section	Mean Rank Score	SD
Challenge Seeking	10.6	1.70
Need for Control	6.4	1.46

Seeking and on the *Need for Control* portions of Part D. Using both the Mann-Whitney U Test and the t-test, only the sub-category *Need for control* was found to have a statistically significant difference ($<.05$) between HCI leaders and PI leaders.

Table 4.16 and Table 4.17 display the mean rank scores for directors characterized as either High-Control Innovator (HCI) or Participative Innovator (PI), in both the *Challenge Seeking* subsection and the *Need for Control* subsection.

Table 4.16

Challenge Seeking and Need For Control Mean Rank Scores for HCI Leaders (n=8)

Sub-Section	Mean Rank Score	SD
Challenge Seeking	10.6	2.39
Need for Control	8.4	.518

Table 4.17

Challenge Seeking and Need For Control Mean Rank Scores for PI Leaders (n=23)

Sub-Section	Mean Rank Score	SD
Challenge Seeking	10.7	1.29
Need for Control	5.7	.974

The Organization

Part B of the questionnaire asked directors to rate their college/university wellness organizations using a five-point Likert scale. From this section, directors were given scores for each of the following areas: Organizational Structure, Organizational Culture, and Strategy. The maximum score for both Structure and Culture was 20. A higher score in the Structure portion indicates a more centralized, control-oriented structure: conversely, a higher score on the Culture section indicates a unicultural organization where diversity is not encouraged. The maximum score for the Strategy section was 25, and a higher score here indicates tendencies toward risk-taking and innovation within the organization. The information in Table 4.18 illustrates the mean rank scores for all respondents.

Table 4.18

Organizational Mean Rank Scores for All Respondents (n=32)

Sub-Section	Mean Rank Score	SD
Structure	13.5	3.50
Culture	11.3	2.13
Strategy	15.6	2.38

The organizational mean rank scores for respondents identified as High-Control Innovators (HCI) and Participative Innovators (PI) are identified in Tables 4.19 and 4.20. Only one respondent was identified outside of these two groups, therefore, no means

could be calculated. That single director was categorized as a Process Manager (PM) leader.

Table 4.19

Organizational Mean Rank Scores for Directors Identified as High-Control Innovators
(n=8)

Sub-Section	Mean Rank Score	SD
Structure	15.4	2.77
Culture	11	2.93
Strategy	15.3	3.53

Table 4.20

Organizational Mean Rank Scores for Directors Identified as Participative Innovators
(n=23)

Sub-Section	Mean Rank Score	SD
Structure	12.9	3.62
Culture	11.3	1.89
Strategy	15.8	1.91

Programming and Leadership

Given that most of the wellness directors in this study (72%) were assessed as Participative Innovators (PI) on the *Strategic Leadership in University/College Wellness Programs Questionnaire*, and that an additional 25% were categorized as High-Control Innovators (HCI), the balance of the sample contained only one director who was identified as a Process Manager (PM). None scored in the Status-Quo Guardians' (SQG) range. Insofar as organizational programming is often a reflection of leadership style, each of the aforementioned categories was analyzed further relative to the types of programs provided by the organization.

Research Question Two

The second question for analysis was, "How is strategic leadership related to the programming and future planning of the university/college wellness/health promotion program?" Data for this question were collected through the *Strategic Leadership in University/College Wellness Programs Questionnaire*. To reiterate, Part A, question 11 asked directors to identify those health promotion information or activities programs that are currently offered by their employee wellness program. Four major programs were identified, along with 17 additional information or activity topics. The programming percentages for the four major health promotion areas for each of the three groups: all respondents, HCI leaders, and PI leaders are displayed in Figure 4.2. All 32 programs offered blood pressure screening, 25 (78%) offered cholesterol screening, and 72 percent (23) offered health status questionnaires. Only 11 (34%) of all programs offered cancer

screenings. There were no significant differences between the HCI leaders and the PI leaders in terms of their offering the four major programs to their employees.

Figure 4.2

Health Promotion Offerings at All Institutions, Institutions Led by HCI Leaders, and Institutions Led by PI Leaders

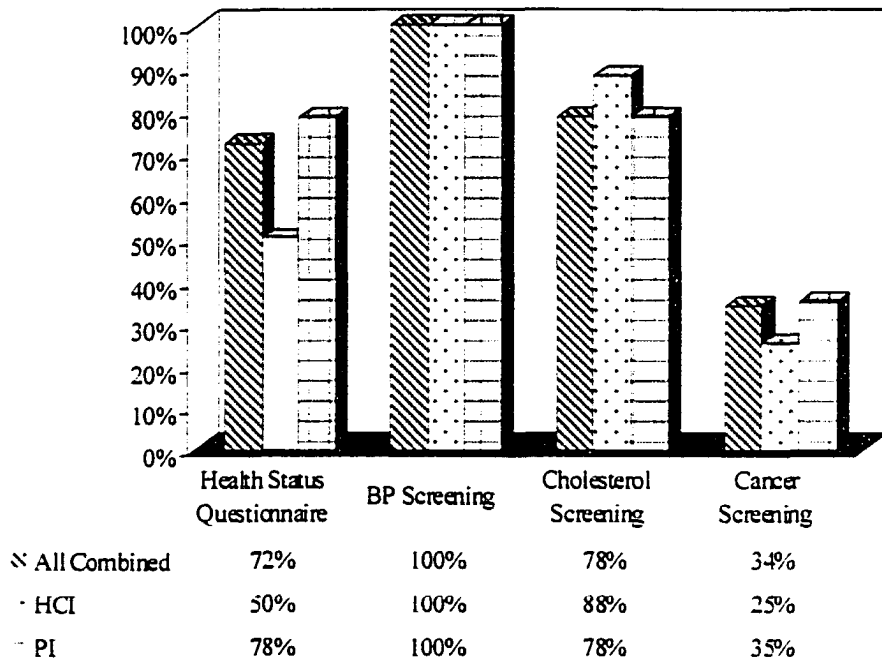


Table 4.21 more clearly depicts the current level of programming in health promotion at colleges/universities overseen by High-Control Innovators. All HCI leaders provided blood pressure screenings for their employees, while an additional 88% provided cholesterol screenings. Fifty percent of High-Control Innovators used a health status questionnaire for employees, and only two (25%) of High-Control Innovators provided cancer screening for their employees.

Table 4.21

Health Promotion Offerings at Institutions Directed by HCI Leaders (n=8)

Health Promotion Offering	N	%a
Health Status Questionnaire	4	50%
Blood Pressure Screening	8	100%
Cholesterol Screening	7	88%
Cancer Screening	2	25%

^aPercentages are rounded to the nearest whole number.

In addition to the programming overseen by High-Control Innovator leaders, special activities and information are offered to employees through university wellness programs. The similarity, summarizing the activities and information offered by institutions directed by HCI leaders is demonstrated in Table 4.22. All High-Control Innovators responded that they often provided employees with information and/or activities for blood pressure management, stress management, exercise and/or fitness programs, and nutrition and cholesterol guidance. Only one director mentioned activities beyond these, citing mental health information, off-the-job accident guidance, and job hazards or injury prevention.

Directors scoring as Participative Innovators (PI) paralleled the research characterizing them as seeking challenges and innovation, while creating a loose, participative, open culture in the organization. That is, the majority of respondents (72%) in this innovation-based field were categorized as Participative Innovators.

Table 4.22

Wellness Information/Activities Offered by Institutions Directed by HCI Leaders (n=8)

Information/Activity	N	%a
Blood Pressure	8	100%
Stress Management	8	100%
Smoking	4	50%
Exercise/Fitness	8	100%
Nutrition	8	100%
Weight Control	5	63%
Mental Health	1	13%
Cancer	4	50%
Back Care	4	50%
AIDS	3	38%
Prenatal	2	25%
Off-the-Job Accidents	1	13%
Cholesterol	8	100%
Alcohol/other Drugs	3	38%
Sexually Transmitted Disease	4	50%
Medical Self-Care	5	63%
Job Hazards/Injury Prevention	1	13%

^aPercentages are rounded to the nearest whole number.

Table 4.23 depicts the basic health promotion program offerings at institutions directed by Participative Innovators, demonstrating consistency with their HCI counterparts.

Table 4.23

Health Promotion Offerings at Institutions Directed by PI Leaders (n=23)

Health Promotion Offering	N	%a
Health Status Questionnaire	18	78%
Blood Pressure Screening	23	100%
Cholesterol Screening	18	78%
Cancer Screening	8	35%

^aPercentages are rounded to the nearest whole number.

While all Participative Innovators offered exercise and fitness information as well as a full slate of activities directed toward those goals, 96% of these directors expanded that mission by offering information or activities on stress management and nutrition. Additionally, of the 17 activities and information topics listed, all but two were incorporated into programs by at least 50% of institutions directed by Participative Innovators. Table 4.24 outlines the various activities or information offered, along with the percentage of institutions directed by PI leaders providing these services. Although there were many reported differences in the percentage of wellness activities and information programs offered by institutions led by High-Control Innovators and Participative Innovators, only two differences can be reported as statistically significant. Programs directed by HCI type leaders and those directed by PI leaders reached a level of significant difference for only weight control activities/information (.05); and job hazard/injury prevention programs (<.05).

Table 4.24

Wellness Information/Activities Offered by Institutions Directed by PI Leaders (n=23)

Information or Activity	N	% ^a
Blood Pressure	20	87%
Stress Management	22	96%
Smoking	18	78%
Exercise/fitness	23	100%
Nutrition	22	96%
Weight Control	21	91%
Mental Health	15	65%
Cancer	16	70%
Back Care	18	78%
AIDS	12	52%
Prenatal	4	17%
Off-the-Job Accidents	3	13%
Cholesterol	20	87%
Alcohol/other Drugs	16	70%
Sexually Transmitted Diseases	12	52%
Medical Self-Care	14	61%
Job Hazards/Injury Prevention	13	57%

^aPercentages are rounded to the nearest whole number.

Wellness/Future Programming

In order to respond to the second part of research question two, an analysis of directors' responses to Part C of the instrument was necessary. Part C of the *Strategic Leadership in University/College Wellness Programs Questionnaire* was comprised of a list of eleven belief statements pertaining to health promotion and future planning. These statements were selected by virtue of their prominence in the literature on wellness, as discussed in Chapter Two. Using a five-point Likert scale, directors responded to these statements by identifying their level of agreement (1= strongly disagree; 2= somewhat disagree; 3= neither agree nor disagree; 4= somewhat agree; and 5=strongly agree). All but one director responded to Part C of the questionnaire. Table 4.25 depicts the mean rank level of agreement to Belief Statement Number 1: "Programming for high-risk employees should be the focus of a wellness or health promotion program." In comparing the High-Control Innovators and the Participative Innovators, using the Chi-square test of Independence, there were no statistically significant differences between their positions on Belief Statement Number 1.

One director who commented on Belief Statement Number 1 said, "Keeping well people well is most cost effective in the long run. Exercise management and a spectrum of health management resources of services should be available." Another director stated, "Wellness program needs to be focused on all populations, at risk or not!" Expounding on this theme, another said, "While they should be the prime focal point. I feel we should emphasize prevention and education and alleviate the 'high-risk' problems before they start." Finally, one summed it up: "It should be for everyone, BUT the

accident rate of our high-risk are killing us.”

Table 4.25

Mean Rank Scores on Programming for High-Risk Employees (n=31)

Belief Statement Number 1

<i>Programming for high-risk employees should be the focus of a wellness or health promotion program.</i>		
Category of Respondent	N	Mean Rank
High-Control Innovator	7	2.71
Participative Innovator	23	2.96
Process Manager	1	4.00
All Respondents	31	2.94

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Although all the directors subsequently interviewed understood the need for reaching high-risk populations (and claimed to), they spoke of the difficulty in reaching those employees. One Participative Innovator stated that her institution has “tried many new and innovative programs and activities in an effort to reach all employees.” One director whose university is self-insured said that he was trying to become “more data driven, in that they were trying to get actual claim data compiled, so they could target their intervention.”

Table 4.26 displays a contingency table of ratings for Belief Statement Number 1: “Programming for high-risk employees should be the focus of a wellness or health promotion program.” Respondents were somewhat split on this item; 45% (14)

somewhat agreed or strongly agreed with the statement, while 39% (12) either strongly disagreed or somewhat disagreed. This response does not hold true for High-Control Innovative leaders, where the majority (71%) disagreed with the statement.

Due to the identification of only a small number of HCI leaders and the fact that there were some missing values, scores 1 (strongly disagree) and 2 (somewhat disagree) were collapsed into one category with the score of 1; score 3 (neither agree nor disagree) was changed to a 2, and scores 4 (somewhat agree) and 5 (strongly agree) were collapsed into one category with the score of 3. This collapse method has been utilized in showing frequency distributions for each of Belief Statements.

Table 4.26

Contingency Table of Rank Scores for Belief Statement Number 1

<i>Programming for high-risk employee should be the focus of a wellness of health promotion program.</i>				
Rank Score	1	2	3	N
PI Leaders	9	4	10	23
HCI Leaders	5	1	3	7
All respondents	12	5	14	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Directors of university wellness programs were asked to respond to the following belief statement: "Health promotion professionals must learn to be sensitive to a new range of people who are as different from each other as they are from the white-collar executives whom health promotion programs are used to serving." One university

wellness director commented, “Everyone is entitled to wellness programming at a low cost.” Another stated, “Our faculty/staff are not extremely diverse, but we should be cognizant of various needs.” Table 4.27 demonstrates the mean rank score for all categories.

Table 4.27

Mean Rank Scores on Learning to be Sensitive to A New Range of People (n=31)

Belief Statement Number 2

<i>Health promotion professionals must learn to be sensitive to a new range of people who are as different from each other as they are from the white-collar executives whom health promotion programs are used to serving.</i>		
Category of Respondent	N	Mean Rank
High-Control Innovator	7	4.57
Participative Innovator	23	4.56
Process Manager	1	4.00
All Respondents	31	4.45

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Table 4.28 is a contingency table of rankings by each of the categories of leaders. All the directors except one agreed either somewhat or strongly with belief statement number two regarding the importance of being sensitive to a new range of constituents. Using the Chi-square test of Independence, no statistically significant difference could be found between the type of innovator (HCI & PI) and rank scores on Belief Statement Number 2.

Table 4.28

Contingency Table of Rank Scores for Belief Statement Number 2

<i>Health promotion professionals must learn to be sensitive to a new range of people who are as different from each other as they are from the white-collar executives whom health promotion program are used to serving.</i>				
Rating Score	1	2	3	N
PI Leaders	0	0	23	23
HCI Leaders	0	1	6	7
All Respondents	0	1	30	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

One Participative Innovator who had been director for just a few months reported that as he has attempted to get the program standardized and formalize systems (no records or forms had been left for him to use by his predecessor), he “hopes to appeal to different cultural and socioeconomic groups on campus, including the working class, and those from the lower socio-economic group.” Another director who serves simultaneously as the safety officer for his institution spoke of the difficulty he experienced when trying to get the physical plant workers involved. He reported that back injuries and workers’ compensation claims at his institution are at an all-time high. In an effort to reduce these claims and improve back wellness, he introduced a one-day back clinic designed specifically to reach this population. Although marketing had been targeted directly toward the physical plant employees, few chose to attend. He felt that many maintained the attitude, “Why should we do this for you?” He continued by stating that his frustration stemmed from the fact that “most don’t take responsibility for their

own physical weaknesses, and they fight the programming efforts implemented to help them improve strength and flexibility, in an effort to reduce injuries.”

Belief Statement Number 3 on the wellness section of the questionnaire asked directors to respond to “outsourcing.” Specifically, Belief Statement 3 stated: “‘Outsourcing’ (contract services) should be used whenever possible.” Table 4.29 reveals the mean ranking for all categories. General comments regarding this statement typically discussed whether or not those services were available on campus and addressed related budget concerns. One director wrote, “Utilize resources within the university first before looking to outside – saves \$ [dollars] utilizes best resources!” However, another director was concerned with quality as evidenced by the comment that outsourcing occurred only “when its service is superior to the ‘In house’.” Most (61%) Participative

Table 4.29

Mean Rank Scores to “Outsourcing” (n=31)

Belief Statement Number 3

<i>“Outsourcing” (contract services) should be used whenever possible.</i>		
Category of Respondent	N	Mean Rank
High-Control Innovator	7	2.14
Participative Innovator	23	3.00
Process Manager	1	1.00
All Respondents	31	2.74

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Innovative leaders neither agreed nor disagreed strongly with the statement, as demonstrated by the mean rank score of a 3.00. However, HCI leaders aligned more closely with the somewhat disagree ranking overall, having a mean score of 2.14. One High Control Innovator reported that at his institution, “there hasn’t been quality or professional people [to contract with].” He also reported that “qualified university staff can do it a whole lot cheaper and increase services to our employees.” This same director, after budget cuts had forced him to cut the full-time nutritionist position, was able to contract back with her “at a much lower rate than what it would have cost them to contract with the dietician from the hospital.”

Whereas most Participative Innovators (61%) had no opinion regarding the statement about contract services, the majority (71%) of High-Control Innovators disagreed with the statement. Table 4.30 reports the contingency table of mean rankings relating to Belief Statement Number 3. No statistically significant difference could be found using the Chi-square test for independence between High-Control Innovator and Participative Innovator leaders, and rank scores on Belief Statement Number 3.

One director stated that within the university “they have access to full-service programming. They have the medical resources necessary to meet their needs.” He felt that it was important to “look internally to the experts on campus ... that will enable us to provide programs.” He continued by stating that philosophically he believed “by using folks on campus first, we work to become more integrated within the university, which in turn helps us to become more important; second, the more people we can reach [via the wellness program] the easier it is for us to move into the departments of the university.

which gives us more exposure, which helps us to become more integral to the university community.”

Table 4.30

Contingency Table of Rank Scores for Belief Statement Number 3

<i>“Outsourcing” (contract services) should be used whenever possible.</i>				
Rank Score	1	2	3	N
PI Leaders	5	14	4	23
HCI Leaders	5	0	2	7
All Respondents	11	14	6	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

When discussing “contract services” with one High-Control Innovator in an interview, he said that “contracting with private vendors is more predictable, and many organizations are attracted to that. They are threatened on the liability issues of wellness, and third party contracting reduces that.” However, he reiterated the fact that he believed “universities have the resources; one just needs to bring them all together.”

With the diversity of the U.S. workforce changing rapidly, directors were asked to respond to a statement based on the individualization of programming for this populace. Belief Statement Number 4 stated, “The diverse workforce of the future will demand programs that are individualized for each sub-population.” One university wellness director heartily concurred, stating that “Targeted services will be most effective, especially in the area of health and disease management.” Agreement further came from

another director who noted, “Everyone should know something about all positions and various health issues.” Table 4.31 reflects the mean rank scores for Belief Statement Number 4.

Table 4.31

Mean Rank Scores on Program Individualization for Sub-Population

Belief Statement Number 4

<i>The diverse workforce of the future will demand programs that are individualized for each sub-population.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	3.70
HCI Leaders	7	3.57
PM Leaders	1	3.00
All Respondents	31	3.65

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Nearly half (48%) of all respondents agreed with the statement related to individualization of programming for diverse sub-populations. Table 4.32 presents the contingency table of rankings for each category. However, 20% of those surveyed had no opinion on this item. Fifty-seven percent (13) of the PI leaders agreed with the statement. No statistically significant difference could be found using the Chi-square test for Independence between the type of innovator (HCI & PI) and rank score on Belief Statement Number 4.

Table 4.32

Contingency Table of Rank Scores for Belief Statement Number 4

<i>The diverse workforce of the future will demand programs that are individualized for each sub-population.</i>				
Rank Score	1	2	3	N
PI Leaders	3	4	16	23
HCI Leader	2	1	4	7
All Respondents	5	6	20	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

The fifth Belief Statement, “Health promotion professionals must be concerned with the selection and implementation of appropriate strategies that help employees to respond to the dual demands of family and work,” showed that nearly all respondents either somewhat agree or strongly agree. Table 4.33 reflects the mean rank scores for Belief Statement 5. All High-Control Innovator leaders strongly agreed with the statement, giving them mean rating score of 5.00. One director characterized the balance inherent in the statement as existing due to a “need with both parents working and/or lots of single parent families.” Only two (6%) respondents neither agreed nor disagreed with the statement. No statistically significant difference could be found using the Chi-square test of Independence, between High-Control Innovators and Participative Innovator leaders and rank scores on Belief Statement Number 5.

One university director spoke of her institution with pride as she said that they had been identified through a national survey “in the top 10% of universities providing a

Table 4.33

Mean Rank Scores on Strategies to Help Employees Deal With the Dual Demands ofFamily and Work.

Belief Statement Number 5

<i>Health promotion professionals must be concerned with the selection and implementation of appropriate strategies that help employees to respond to the dual demands of family and work.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	4.57
HCI Leaders	7	5.00
PM Leader	1	4.00
All Respondents	31	4.65

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score = 3.

family-friendly environment.” She said they continue to work hard to provide that atmosphere. Examination of Table 4.34 shows that twenty-two (71%) of all respondents strongly agreed with the need for health promotion professionals to use strategies that help employees respond to the demands of both family and work. Nearly all (91%) of those identified as Participative Innovative leaders either somewhat agreed or strongly agreed with this.

Belief Statement Number 6 asked directors to respond to this statement: “A greater understanding of the cultural needs of employees should be considered when

Table 4.34

Contingency Table of Rank Scores for Belief Statement Number 5

<i>Health promotion professionals must be concerned with the selection and implementation of appropriate strategies that help employees to respond to the dual demands of family and work.</i>				
Rank Score	1	2	3	N
PI Leaders	0	2	21	23
HCI Leader	0	0	7	7
All Respondents	0	2	29	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score = 3.

establishing future programs.” The mean rank for all respondents was 4.29; these rankings were just slightly higher (4.43) for High-Control Innovators. Table 4.35 depicts these results.

Twenty-six (84%) of all respondents agreed that an employee’s cultural needs should be considered when establishing future programs. No directors disagreed with the statement; however, five (16%) neither agreed nor disagreed with the statement.

Responding to Belief Statement Number 6, one director commented, “Culture can mean many things, not just ethnicity i.e., drinking culture.” Another director remarked that at her campus the population “is very diverse, I love that!” She continued by asserting, “we need to do more in that area [programming for cultural diversity], and have looked into providing ethnic dance and diet and cuisine programs related to cultural needs.” Using the Chi-square test of Independence, no statistically significant difference could be found between the type of innovator (HCI & PI) and rank scores on Belief

Table 4.35

Mean Rank Scores on Understanding Employee Cultural Needs and Future Programs

Belief Statement Number 6

<i>A greater understanding of the cultural needs of employees should be considered when establishing future programs.</i>		
Category of Respondents	N	Mean Rank
All Respondents	31	4.29
PI Leaders	23	4.30
HCI Leaders	7	4.43
PM Leader	1	3.00

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Statement Number 6. Table 4.36 reflects the contingency table for all categories.

Table 4.36

Contingency Table of Rank Scores for Belief Statement Number 6

<i>A greater understanding of the cultural needs of employees should be considered when establishing future programs.</i>				
Rank Score	1	2	3	N
PI Leaders	0	3	20	23
HCI Leaders	0	1	6	7
All Respondents	0	5	26	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Table 4.37 reflects the mean rank scores for all leader categories with regard to Belief Statement Number 7. A mean rank score of 4.29 for all respondents, to Belief Statement Number 7: “Family-centered programs can help reduce the health care costs and health risks of family members” was established. Here, wellness directors agreed that family-centered programs can help reduce the health care costs and health risks of family members. Pondering this issue, one director commented that “dependents consume a large portion of health benefit dollars.” Another cautioned that family needs not be an assumed goal, noting that “not all have family or dependents – other community programs serve young people.”

Table 4.37

Mean Rank Scores on Whether Family-Centered Programs Can Help Reduce Health Care Costs and Health Risks

Belief Statement Number 7

<i>Family-centered programs can help to reduce the health care costs and health risks of family members.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	4.35
HCI Leaders	7	4.14
PM Leader	1	4.00
All Respondents	31	4.29

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Table 4.38 shows that only two (6%) of all respondents disagree that family-centered programs can help reduce health care costs and health risks of family members. Most directors (90%) agreed that family-centered activities may reduce health care costs and individual risks. Not statistically significant difference could be found using Chi-square test of Independence, between High-Control or Participative Innovator leaders and rank scores on Belief Statement Number 7.

One director reported that although family-centered programming might be important, his institution cannot service families. “[These programs are not permitted to] compete with private enterprises.” Therefore, programming is limited to employees and their spouses. One director with programs she considered “cutting edge,” said wellness directors must be concerned with “the work-family relationship.” At her institution,

Table 4.38

Contingency Table of Rank Scores for Belief Statement Number 7

<i>Family-centered programs can help to reduce the health care costs and health risks of family members.</i>				
Rank Score	1	2	3	N
PI Leaders	1	1	21	23
HCI Leaders	1	0	6	7
All respondents	2	1	28	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

“stress and the effects of stress, are one of the biggest concerns when programming.

Most employees are being asked to do more with less, and at the end of the day they must

get out and take care of the rest of their responsibilities. It is important that we see what the people need.”

The majority (84%) of all university wellness directors agreed with Belief Statement Number 8: “University wellness programs should offer programming strategies for differing age groups” as revealed in Table 4.39. For each of the groups, all rating scores were above the 4.00 (somewhat agree) range. One director responded that “all programs can be modified for the population (age group).” Another director wrote that “our first priority should be faculty/staff who are all adults, [but] some ‘generational’ NEEDS should be considered, of course.” One director stated that it was important to program for “ages and stages of need; level of fitness.” Those directors who self-selected for the follow-up phone interview were very aware of the needs of their different age

Table 4.39

Rank Scores on Programming for Differing Age Groups

Belief Statement Number 8

<i>University wellness programs should offer programming strategies for differing age groups.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	4.30
HCI Leaders	7	4.29
PM Leader	1	2.00
All Respondents	31	4.23

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

groups and spoke of the changing age of their employees. One director stated that she “would like to provide for everyone, how to go about doing that is the question.” This director also said it was “important to be aware of the age demographics and the needs of each group, however, we can’t lose sight of the younger people.”

A contingency table reveals that only one (3%) respondent disagreed with offering programming strategies for differing age groups. Eighty-four percent (26) of the directors agreed with this strategy. Table 4.40 depicts all leader categories. Two directors expressed a concern for the budget required to fulfill this strategy, commenting, “If budget allows!” and “Resources.”

A crosstab analysis of Belief Statement Number 8 displayed a Chi-square test of Independence statistic of 32.074, and a $p < .05$, indicating an interaction between type of leader and rank response to Belief Statement Number 8.

Table 4.40

Contingency Table of Rank Scores for Belief Statement Number 8

<i>University wellness programs should offer programming strategies for differing age groups.</i>				
Rank Score	1	2	3	N
PI Leaders	0	3	20	23
HCI Leaders	0	1	6	7
All Respondents	1	4	26	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

Belief Statement Number 9 stated: "Programming should focus on individualizing to better meet employee needs." As one director exclaimed, "[Individualization is] the key to retention!" Others reported concerns about staffing and budget. One director agreed with the caveat: "If you have the staff to do it," echoed by another who said, "Within budget/staff constraints." A third noted the same theme, stating "This takes more resources, but people will be able to access individualized choices thorough internet/intranet services." In response to Belief Statement Number 9, rank scores for all respondents was 3.82. This parallels very similar results for all categories as shown in Table 4.41.

Table 4.41

Rank Scores on Individualizing Programming to Better Meet Employees Needs

Belief Statement Number 9

<i>Programming should focus on individualizing to better meet employee needs.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	3.91
HCI Leaders	7	3.57
PM Leader	1	4.00
All Respondents	31	3.82

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

In relation to Belief Statement Number 9, a High-Control Innovator stated that "we need to move away from activity programming to more of a risk management." He

commented further that “we do a poor job of incorporating wellness into Human Resources and the benefits position.” He felt that wellness programs should work more closely with new employee orientation: “By reaching new employees, we can ensure that they are knowledgeable of the individual services we offer.” Table 4.42 reflects the contingency table of rank scores for all respondents. Using the Chi-square test of Independence no statistically significant difference could be found between High-Control or Participative Innovator leaders and rank scores on Belief Statement Number 9.

Table 4.42

Contingency Table of Rank Scores for Belief Statement Number 9

<i>Programming should focus on individualizing to better meet employee needs.</i>				
Rank Score	1	2	3	N
PI Leaders	3	3	17	23
HCI Leaders	0	3	4	7
All Respondents	3	6	22	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

The majority (74%) of Participative Innovator leaders agreed that programming should focus on individualizing to better meet employee needs. Fifty-seven percent (4) of High-Control Innovator leaders agreed with the statement, while forty-three percent (3) of the HCI leaders had no opinion.

To identify university wellness directors’ beliefs regarding the use of benefit-cost analysis, the instrument sought responses to the following statement: “Benefit-cost

analysis (BCA) should be used to evaluate a program's success or value." Response to the statement showed a mean rank score of 3.35. Here, High-Control Innovators had no opinion, while the mean rank score for Participative Innovator leaders was slightly higher at 3.48. The rank scores for all categories are displayed in Table 4.43.

Table 4.43

Rank Scores on Using Benefit-Cost Analysis to Evaluate a Program

Belief Statement Number 10

<i>Benefit-cost analysis (BCA) should be used to evaluate a program's success or value.</i>		
Category of Respondent	N	Mean Rank
PI Leaders	23	3.48
HCI Leaders	7	3.14
PM Leader	1	2.00
All Respondents	31	3.35

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score = 3.

Many directors chose to comment on Belief Statement Number 10, with one director writing that "the program needs to be cost effective, but it also needs to meet the needs of clients." Another expressed a philosophical conundrum by stating, "How do we put monetary value on morale, wellness, etc?" Additionally, one director noted that "dollar values should not be the bottom line. A quantity/quality equity needs to be achieved." Others were concerned about the measurement issue: "it's hard to measure 'cost-effectiveness' of prevention programs." Two noted the connection to planning, said

one: “trend data over a period of time will be needed,” and another director concurred: “it depends on goals and objectives.”

Fifty-two percent (16) of all respondents agreed with the use of benefit-cost analysis to evaluate a program’s success or value, although nearly one-third (29%) of the directors disagreed somewhat with its use in evaluation. Over half (57%) of the Participative Innovator leaders agreed with its use compared to 43% of the High-Control Innovators. No statistically significant difference could be found using the Chi-square test of Independence between HCI and PI leaders and rank scores on Belief Statement Number 10. Table 4.44 outlines the rank scores for each of the categories.

Table 4.44

Contingency Table of Rank Scores for Belief Statement 10

<i>Benefit-cost analysis (BCA) should be used to evaluate a program's success or value.</i>				
Rank Score	1	2	3	N
PI Leaders	6	4	13	23
HCI Leaders	2	2	3	7
All Respondents	9	6	16	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

The final Belief Statement on Part C of *The Strategic Leadership in University/College Wellness Programs Questionnaire* asked directors to respond to a statement regarding the leader’s role. Belief Statement Number 11 read: “A leader’s role is one of guidance and support.” The rank score (4.45) demonstrates that the respondents

overwhelmingly agreed strongly that the leader's role should be one of guidance and support, as Table 4.45 shows. However, one director stated her concerns when she added, "This is a business first and foremost and though it would be great to provide support we're so stretched we need support ourselves!" Another director reported that the upper administration at his institution "talks the talk but does not walk the walk. There [have] been new administrative changes; we will see how this will affect the wellness program." Consistent with the literature, one university wellness director was

Table 4.45

Rank Scores on A Leader's Role Is One of Guidance and Support.

Belief Statement Number 11

<i>A leader's role is one of guidance and support.</i>		
Category of Respondents	N	Mean Rank
PI Leaders	23	4.48
HCI Leaders	7	4.43
PM Leader	1	4.00
All Respondents	31	4.45

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

frustrated by the difficulties leaders in this field face when confronted with goals directed toward changing human behavior: "It has been difficult to get the majority to change their life-style. Most are not into fitness. Those that are into fitness do so on their own free will and they don't need a wellness program as much as those that don't take care of

themselves. How do you change behavior?” Nonetheless, the leaders did view their roles as providing guidance and support.

The crosstabulation displayed in Table 4.46 shows that 90% of all respondents agreed that a leader’s role is one of guidance and support. Only one respondent disagreed with the statement. Seventy-one percent of the High-Control Innovator leaders strongly agreed with the statement, while 57% of Participative Innovator leaders did the same. Using the Chi-square test of Independence, no statistically significant difference could be found between innovators (HCI & PI) and rank scores to Belief Statement Number 11.

Table 4.46

Contingency Table of Rank Scores for Statement 11

<i>A leader's role is one of guidance and support.</i>				
Rank Score	1	2	3	N
PI Leaders	1	0	16	23
HCI Leaders	0	2	5	7
All Respondents	1	2	28	31

Note: strongly disagree (1) and somewhat disagree (2) were collapsed into one score = 1; neither agree nor disagree (3) was changed to a 2, and scores somewhat agree (4) and strongly agree (5) were collapsed into one score =3.

One interviewee characterized her role’s influence as having created an environment of “approachability,” which she believed to be the greatest strength of her program. She described this by stating that “people know that they can come in and ask questions, and we always try to be open to the comments of the people that walk into my office.”

Subquestion One

The organizational structure of the director's program was determined using portions of Part B of the *Strategic Leadership in University/College Wellness Programs Questionnaire*. Subquestion one for analysis was: Is the type of organizational structure of the university wellness/health promotion associated with the leader's strategic leadership style? A score for organizational structure was determined by the director's response to four statements about their organization. A sum of the four Likert items therefore held the potential to result in a maximum score of 20. A higher score in the structure portion indicated a more centralized, control-oriented structure. Using the Chi-square test of Independence, no significant statistical difference could be found between the organizational structures managed by High-Control Innovator type leaders and the organizational structures overseen by Participative Innovators.

Subquestion Two

Subquestion two was used to analyze whether or not the organizational culture of the university wellness/health promotion program was related to the leaders' strategic leadership style. Again, the instrument utilized Likert-type questions to determine a score for each individual director's organizational culture. Each director could record a maximum score of 20, with higher scores indicating a unicultural organization where diversity is not encouraged. Using a Mann-Whitney U Test, no statistically significant

difference was found between the organizational cultures of High-Control Innovator leaders and those managed by Participative Innovators.

Subquestion Three

In order to ascertain the answer to subquestion three, qualitative data gathered in the post-hoc interviews was analyzed. Subquestion three asked: What is the nature of the future planning process implemented by different types of strategic leaders? From the initial qualitative sample, each director had an opportunity to agree to participate in a follow-up interview. Nineteen (59%) of the directors responding to the survey offered to be included in the follow-up interviews. Of those 19 directors, 12 were identified as Participative Innovators; five were categorized as High-Control Innovators; and one was determined to be a Process Manager. From among these, the four top-ranking High-Control Innovator leaders were selected to be interviewed, along with the four top-ranking Participative Innovators. The HCI and PI leaders were juxtaposed based on the strength of their grouping within the category. Their responses were expected to provide insight into the leadership styles typified by the directors of wellness programs participating in this investigation.

Through the use of in-depth telephone interviews, it was possible to discuss programming and planning changes at individual institutions with each director. When asked about how they build their personal concerns into the strategic planning process, one High-Control Innovator said that she spends a great deal of time researching what is going on in the wellness field by “reading articles and searching the web.” She further

claimed to have implemented numerous new programs whose ideas came from a variety of resources, including professional literature in the field and – most often – from some salient need observed from within her organization. She herself networked within her field and organization as well as, internally at her university. There she believed the Human Resource and Personnel directors to be of the greatest help in identifying the problems or needs of the employees at their university. This director also believed that the support she received from her supervisor to be essential. When she had a new idea he said, “Go ahead and do it.” Among her guiding organizational beliefs was the commitment that her program should demonstrate “traditional wellness while being progressive and delivering programs that are ‘cutting edge’ ... and for me to be a leader in the field, not a follower.”

When discussing programming changes, one director, who is relatively new in her position, said that the “administration lets me do what I see as a need. They show complete confidence in me and they let me do what I want to do in terms of planning ahead for next year.” She continued by stating that she always “leaves room in the budget for new programs.” In that particular geographic area, this director had “lots of wellness organizations” from whom she can draw ideas.

One High-Control Innovator, whose institution offers a wellness program, yet does not allocate any funds to implement it, said that he uses his advisory board to develop and implement programs. In further discussions about programming, and how he implements change he noted that the advisory board before “had lots of ideas, but did no work,” now that same board is a “working board.” Board members now “take an idea from infancy all the way through to implementation of the activity.”

When discussing program change and its implementation, most of the directors were quick to give credit to their staff. Although, many had full-time assistants others had the use of graduate students. One Participatory Innovator, said that their organization was “structured, in that each of the full time staff have a clear area, and they are in charge of that. He fills in the gaps, providing leadership and direction for the whole program. Unfortunately, that is less hands on.” A High-Control Innovator said “I brought the idea [for a new program] to my staff, but they added nuts and bolts, and made it work.”

Many of the directors said that they were usually the ones who came up with new programming ideas, with one saying “ideas come from him,” and another saying “it’s my game, a one person show as it is now, and how it has been run in the past.” Regardless of the origination of the idea for change, the wellness director had the final decision as to whether or not changes would be implemented.

Summary

Each of the university wellness directors contributing to this study was categorized as an innovator as measured by Part D of the *Strategic Leadership in University/College Wellness Programs Questionnaire*. Throughout the research process, these university wellness directors provided numerous examples of their innovations. Many directors themselves generated the idea for employee wellness, sold that idea to administration, and then implemented the program at their institution. Each institution had unique needs, which necessitated an innovative leader.

Creating a wellness program is a relatively new endeavor for most universities. Due to the recent emergence of wellness as a professional field and practice, the leadership of program directors is critical to the evolution and continued development of wellness. The directors of wellness constituting the sample in this study were able to design and implement new programs for the employees at their institutions. Although many programming differences were evidenced, each director was keenly aware of the critical balance between meeting the needs of and striving to involve high-risk employees, while continuing to provide wellness programs for traditionally active groups.

CHAPTER FIVE

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The subjects of this study constituted a unique group of organizational leaders. They tended to describe their positions as “rewarding,” a “chance to truly make a difference,” and “a challenge.” Organizationally, some directors were responsible solely for the employee wellness program at their institution, while others had additional responsibilities in such areas as student wellness, managing athletic/recreational facilities, or university safety oversight. Many of their programs were multi-faceted, while others offered more one-dimensional programming.

Findings

Both the quantitative and qualitative data included information describing the contexts of the organizations in which the wellness directors operate. These included information on activity programs, informational programs, and budget. Data collection involving a survey instrument, leadership assessment, written commentary and post-hoc interviews resulted in a comprehensive analysis designed to respond to the research questions outlined in Chapter One.

Program Characteristics:

- All university programs offered blood pressure screening, while the vast majority provided cholesterol screening (78%) and used health status questionnaires (72%); however, only 34% offered cancer screenings.
- All institutions offered exercise/fitness activities, and 85% or more offered information and/or activities on blood pressure reduction, cholesterol, stress management, nutrition, and weight control.
- Most colleges/universities (58%) reported that university wellness programming was open to employee spouses and dependents, an additional 13% reported that only an employee's spouse may participate, and 29% reported that no one other than the employee was permitted to participate.
- Of those programs allowing spouses and/or dependents to participate, 68% reported charging a fee for those services.
- Yearly operating budgets ranged from \$0.00 to \$1,000,000. Forty-four percent of directors report having a budget of \$50,000 or less, while only 11% reported budgets in excess of \$200,000.

Research Question Number One: What type of strategic leaders are found in university/college wellness/health promotion programs?

- Most (72%) of the university wellness directors were categorized as Participative Innovators. An additional 25% were identified as High-Control Innovators.

- Statistical Significance difference ($<.05$) was found on the leaders level of “need for control” between Participatory Innovator and the High-Control Innovator leaders.
- The majority (75%) of the directors surveyed reported at least four or more years of experience as a director of wellness or health promotion at a college or university. The mean number of years for this study reflected 6.8 years of experience in the field. Fifty-nine percent of the directors had four or more years experience at their current institutions, while 28% had one year or less.
- Most directors (59%) held a Master’s Degree, while 28% held a terminal or Doctoral Degree. The most prevalent field of study was Exercise Physiology/Exercise Science. Of those directors having completed a Master’s Degree, 32% studied in the field of Exercise Science; and of those directors completing their Doctoral Degrees, 44% were in Kinesiology/Exercise Science.
- A recurring theme that emerged through the interview process was that many wellness directors had “sold” themselves and their program to upper managers thus, creating their wellness position. One such director recounted by saying. upon completion of her master’s program “she was asked by the human resources personnel what her plans were. She said that she was looking at the possibilities of consulting with private businesses to establish wellness programming for their employees.” University personnel subsequently asked her to develop and present a proposal for wellness programming at their

institution. Consequently, she created and is now directing wellness programming for two of the states public colleges/universities.

Research Question Number Two: How is strategic leadership related to programming and future planning of the university/college wellness/health promotion program?

- Programs directed by HCI type leaders and those directed by PI leaders reached a level of statistical significant difference for only weight control activities/information (.05); and job hazard/injury prevention programs ($p < .05$). Programs directed by Participative Innovators were more likely to provide weight control activities/information and job hazard/injury prevention programs for employees.
- Participative Innovator leaders were more likely (78%) to offer health status questionnaire than HCI leaders (50%).

Subquestion Number One: Is the type of organizational structure of the university wellness/health promotion program associated with the leader's strategic leadership style?

- No statistically significant differences were found using the Chi Square test for Independence between the organizational structures of High-Control Innovator type leaders and those identified as Participative Innovators.
- No Status Quo Guardian leaders emerged in this sample, and only one Process Manager leader was identified.

Subquestion Number Two: Is the organizational culture of the university wellness/health promotion program related to the leader's strategic leadership style?

- Using the Mann-Whitney U test, no statistically significant difference was found between the organizational cultures of High-Control Innovator leaders and those managed by Participative Innovators.
- No Status Quo Guardian leaders emerged in this sample, and only one Process Manager leader was identified.

Subquestion Number Three: What is the nature of the future planning process implemented by different types of strategic leaders?

- No statistically significant differences could be established between the future planning processes implemented by either High-Control Innovator leaders or Participative Innovator leaders.
- No Status Quo Guardian leaders emerged in this sample, and only one Process Manager leader was identified.
- Most college/university wellness program directors (59%) indicated that they had an employee wellness advisory board. The make-up of the board and its role varied from institution to institution. Many directors simply "bounced ideas off" their board, while others required board members to help plan and implement programs.

- All directors reported that they made the final decision regarding the implementation of new programs.
- Most directors were the origin of ideas for future planning and the implementation of program changes; however, new ideas came from a variety of sources including, human resources personnel, participant-employee interaction, and from the wellness staff.

Conclusions

The emergence of employee wellness programs is a relatively new concept. Since most programs are less than 20 years old, protocols and procedures have not yet become consistent across many institutions. The dynamic nature of the programs themselves has clearly attracted many innovators to their leadership. While causality cannot be inferred from these data, the findings clearly established that the wellness directors are innovators in two dimensions: High-Control and Participative. In many cases, these directors actually created their own positions. Further, the wellness field – being relatively amorphous in the absence of national standards – has largely reflected the programs conceptualized by each individual leader at a wide array of institutions.

Identifying these leaders as innovative constitutes a surprising conclusion and results in several deeper questions: why are there no Status Quo Guardians or Process Managers directing wellness program? Perhaps in the case of the former, the organizations newness mitigates the assistance of any status quo to guard. In the case of the latter, there are few processes well enough established nationally to manage. Given the historical tendency for new university organizations to become mired down in

traditional, non-risk taking leadership styles (e.g. technology administrators, human resource managers), it is uplifting to see innovators still at the core of the wellness movement.

Directors who are creative and innovative in programming and problem solving typify the leadership style in this field. Most directors are trying to establish and create programs to meet the needs of a diverse group of users. All programs studied offered exercise and fitness activities, but these university wellness directors tended to speak of the need to move from an exercise-based program to one that offers a comprehensive array of cutting-edge services. Said one: "Traditional methodology is disappearing: we need to find unique ways to get information out. We have a web page and interactive video to move from an island (doing what we have always done) to where we are an integrated part of the system. We (wellness directors, human resources and personnel, and workers' compensation) managers need to integrate an intervention of medical management strategy for the university, providing good customer service and a personalized program."

Nearly all respondents could be categorized as innovators, with 72% identified as Participative Innovators and another 25% as High-Control Innovators. The only significant difference ($p < .05$) was found between their "need for control." Although all these directors were innovators, the post-hoc interviews revealed that this "need for control" was related primarily to the rapid pace of their organizations. For example, most directors sought input on programming ideas from a number of sources, including human resources, survey instruments, wellness advisory boards, and conversations with employees. Seeking input from these sources is characteristic of a collaborative or

participative leadership approach. However, many of these same directors also generated many new program ideas, planned and implemented them. At other times they brought a new idea to their staffs, and the staff then saw these ideas through to completion. Hence, despite their control, all the directors discussed how important their staffs were to the operation of the university wellness programs. Even those who did not have ancillary staff found support and sought input through the use of student workers, mostly graduate students. This dichotomy between the desire to seek input and the desire to be in control is characteristic of effective leadership of organizations still in the process of clarifying their missions, as these are currently undergoing. This research underscored the fact that despite their differences, both HCI and PI leaders operate collaboratively in strategic planning for wellness.

Many components of a wellness program revolve around the kind of budget that exists. It was not surprise to learn that those programs given adequate budgets were more likely to provide greater diversity in programming. Several directors reported that they had a zero budget, but were still expected to provide wellness services. Many responded that their budgets had suffered severe cuts in the last few years, and several others reported that their entire programs had fallen victim to budget cuts. Nonetheless, the directors of wellness programs had become highly creative in continuing programs despite severe budget constraints. One such director said he had been able to “rehire a nutritionist on an hourly contract” in an effort to save that dimension of programming. Another used the cheap labor provided in-house: “When [the university] buys my time. I turn that money around and pay graduate students to help. Their primary responsibility is to help with those contracts. I do all the big stuff, but the graduate students can do all the

little clerical things. As money comes and goes, so do the students.” Another director who has no budget expressed frustration at the difficulty in operating on a shoestring. Still, he sponsored walking tours, some speakers, and some “for fee” programs, resulting in an amazingly diverse set of offerings.

Over half of those directors responding to the survey had been in their current position for a minimum of four years, allowing them adequate time to understand the structure and culture of their particular university. Such longevity in a transitional type of organization is unique. Clearly, these directors find their positions to be their professional pinnacles. The organizational growth and cutbacks were not viewed as detrimental but appeared, instead, to be viewed as inherent in the job itself.

In addition to the fact that innovators, by nature, have been drawn into the leadership of wellness programs; that they tend to stay in their positions overtime; that they are simultaneously participative and controlling in the planning process; and that they are creative instead of complacent in the face of budgetary reductions; it should be further noted that these subjects were also optimistic about their ability to play a meaningful role as a campus unit. One captured the essence of several interviews in asserting: “We have the people and resources we need. Now we just have to put all those together.” Similarly, they tended to find their work meaningful, as one commented: “We are working more diligently on helping our employees to personalize [our programs].”

In conclusion, this research detailed the characteristics of wellness programs as a function of their specialized leadership. The subjects in this study consistently exhibited the following characteristics: they were strongly motivated, they had been well trained in specialized health promotion areas associated with their work, they empowered their

employees and spoke of their own empowerment by superiors, and they were “other focused” in their determination to serve the many participants in their programs. In short, they approached their organizational goals with a contagious zeal and passion for change.

Recommendations

The following recommendations emerged from this study:

- Universities should provide employees in leadership positions with some specialized training in strategic planning. Training should emphasize an openness to change, innovation, and risk-taking; long with a focus on future needs and trends. Preparation should guide these future leaders toward a better understanding of how they must anticipate, that essentially, they will become managers of the unknown.
- Universities should establish a specific budget for employee wellness services, to be managed by the director of employee wellness.
- Employee wellness directors should work collaboratively with the department of human resources and insurance companies to better understand and meet the needs of university employees.
- Directors of universities/colleges employee wellness programs should establish some networking communication links to promote the exchange of ideas and information regarding successful wellness programs and leadership strategies.

- The *National Wellness Resource Information Directory: Wellness in Higher Education*, must refine its membership database to clarify which institutions offer employee wellness programs and which do not.

Recommendations for Further Research

Both qualitative and quantitative data enabled the researcher to clearly see how eager university wellness directors were to find out about leadership. Nearly all directors were enthusiastic in wanting summary information about this study. It was clear from the verbal comments and the number of written responses, that university wellness directors held strong views and felt compelled to provide more specific details about their wellness program. As a result, the following recommendations are presented for further research:

Leadership

- Better determination of leadership training needs in higher education.
- Study other units in higher education to determine which types of strategic leaders (High-Control Innovators, Participative Innovators, Process Managers, and Status Quo Guardians) currently oversee other fields.
- Further research is necessary in the area of leadership type to further delineate the characteristics of leaders in complex, new organizations attempting to create and describe emergent missions.
- Research should be conducted to examine the practice of combined student/employee wellness programming.

- Research should be conducted to determine where an employee wellness program is best placed within the structure of a college/university.
- Continued research is necessary to determine how to involve “high-risk” employees in university wellness programs.
- Further research is necessary to determine if a statistical difference could be established between the organizational structure of a Participative Innovator type leader and the organizational structure of a High-Control Innovator leader. This study did not find statistical significance using a two-tailed test ($p=.06$) however, the use of a one-tailed test in subsequent research may establish a significant difference between the organizational structure of a PI leader and a HCI leader, using a more powerful statistical instrument.
- An emerging issue from this research begs the question: Does an innovative leader create an innovative organization, or does an innovative organization create an innovative leader? Research addressing leadership issues causal manner would have a powerful impact on the field.

Endnote

Wellness directors on college or university campuses are a progressive lot. It may be that their perspective is best expressed in the words of one participant in this study:

My goal has always been to deliver programs that demonstrate traditional wellness while being progressive and cutting edge... I want to be a leader in the field, not a follower.

Nancy, a university wellness director

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APPENDICES

Appendix A**Email from Nahavandi**

Subject:
Permission to use your strategic Leadership stuff
Date:
Wed, 16 Dec 1998 11:36:14 -0700 (MST)
From:
"Afsaneh Nahavandi," <ATAYN@ASUVM.INRE.ASU.EDU>
To:
theck@SHERBTel.NET

____ Professor of Management ASU West
Please feel free to use the strategic leadership instrument in my
Leadership book. Good luck on your defense.

-- Afsaneh (3-6206)

Appendix B – Survey Instrument (Page 1 of 4)
Strategic Leadership in University/College Wellness Programs

Directions:

This questionnaire is divided into four parts: 1) a set of general questions; 2) a section about your wellness organization; 3) a section concerning wellness; and 4) a set of statements about strategic leadership. Please respond to each statement using the scale provided. Please make comments or explanations if necessary.

Part A: General Information

1. How many total years of experience do you have as a director of health promotion or wellness?

2. How many years/months of experience do you have as director at the current institution?

_____ years _____ months

3. What is your present level of education? And in what area?

_____ Baccalaureate degree
 Degree/Major field of study _____

_____ Master's Degree
 Degree/Major field of study _____

_____ Doctoral Degree
 Degree/Major field of study _____

4. Your gender: _____ Male _____ Female

5. How many employees are there at your institution?

_____ full-time _____ part-time

6. Approximately how many employees currently use your health promotion/wellness services?

7. Are spouses or dependents allowed to participate in university/college wellness program?

_____ spouse's only _____ spouses and dependents may participate

_____ no one other than employees may participate

8. Is there a fee for spouses or dependents to participate in university/wellness programs?

_____ yes, there is a fee

_____ no, there is no fee

_____ if a fee is assessed, please specify: _____ amount

_____ program

9. What is your yearly operating budget? _____

10. Do you have an employee wellness advisory board?

_____ yes _____ no

Appendix B – Survey Instrument (Page 2 of 4)

Regarding your current wellness program:

11. Which of the following health promotion information or activities are currently offered by your employee wellness program? Please check all that apply.

☐ Health status questionnaires ☐ Cholesterol screenings

☐ Blood pressure screenings ☐ Cancer screenings

Information or Activities on:

☐ Blood pressure ☐ Mental health ☐ Cholesterol

☐ Stress Management ☐ Cancer ☐ Alcohol/other drugs

☐ Smoking ☐ Back care ☐ Sexually transmitted diseases

☐ Exercise/fitness ☐ AIDS education ☐ Medical self-care

☐ Nutrition ☐ Prenatal education ☐ Job hazards/injury prevention

☐ Weight Control ☐ Off-the-job accidents ☐ Others, please specify:

Part B: Your Organization

Directions: Rate your organization on the following items, using the following scale. The organization you will be rating is the college/university wellness program that you direct:

1	2	3	4	5
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

- ☐ 1. Decision making in my organization is very centralized.
- ☐ 2. There is a very strong, thick culture in my organization.
- ☐ 3. We are always coming up with new ways of doing things.
- ☐ 4. A few people make most of the important decisions.
- ☐ 5. There are many subgroups and cliques.
- ☐ 6. Our primary concern is efficiency.
- ☐ 7. We are known for our ability to innovate.
- ☐ 8. We are open to differing points of views.
- ☐ 9. Employees are empowered to make many decisions without checking with management.
- ☐ 10. We have not changed our course much in the past few years.
- ☐ 11. We take many risks.
- ☐ 12. There are many rules and procedures for our tasks.
- ☐ 13. People are encouraged to do their own thing.

Appendix B – Survey Instrument (Page 3 of 4)

Part C: Wellness

Directions: Using the following scale, respond to each of the following statements:

1	2	3	4	5
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

_____ 1. Programming for high-risk employees should be the focus of a wellness or health promotion program.

Comments:

_____ 2. Health promotion professionals must learn to be sensitive to a new range of people who are as different from each other as they are from the white-collar executives whom health promotion programs are used to serving.

Comments:

_____ 3. "Outsourcing" (contract services) should be used whenever possible.

Comments:

_____ 4. The diverse workforce of the future will demand programs that are individualized for each sub-population.

Comments:

_____ 5. Health promotion professionals must be concerned with the selection and implementation of appropriate strategies that help employees to respond to the dual demands of family and work.

Comments:

_____ 6. A greater understanding of the cultural needs of employees should be considered when establishing future programs.

Comments:

_____ 7. Family-centered programs can help to reduce the health care costs and health risks of family members.

Comments:

_____ 8. University wellness programs should offer programming strategies for differing age groups.

Comments:

_____ 9. Programming should focus on individualizing to better meet employee needs.

Comments:

_____ 10. Benefit-cost analysis (BCA) should be used to evaluate a program's success or value.

Comments:

_____ 11. A leader's role is one of guidance and support.

Comments:

Appendix B – Survey Instrument (Pages 4 of 4)

Part D: What is Your Strategic Leadership Type?

For each of the following items, please rate yourself using the following scale.

0	1	2	3
Never	Sometimes	Often	Always

- _____ 1. I enjoy working on routine tasks.
- _____ 2. I am looking for new ways of doing things.
- _____ 3. I have trouble delegating tasks to my subordinates.
- _____ 4. I like my subordinates to share the same values and beliefs.
- _____ 5. Change makes me uncomfortable.
- _____ 6. I encourage my subordinates to participate in decision making.
- _____ 7. It is hard for me to get things done when there are many contrasting opinions.
- _____ 8. I enjoy working on new tasks.
- _____ 9. I feel comfortable giving power away to my subordinates.
- _____ 10. I consider myself to be a risk taker.

Thank you for taking time out of your busy schedule to complete this survey. Your input is greatly appreciated.

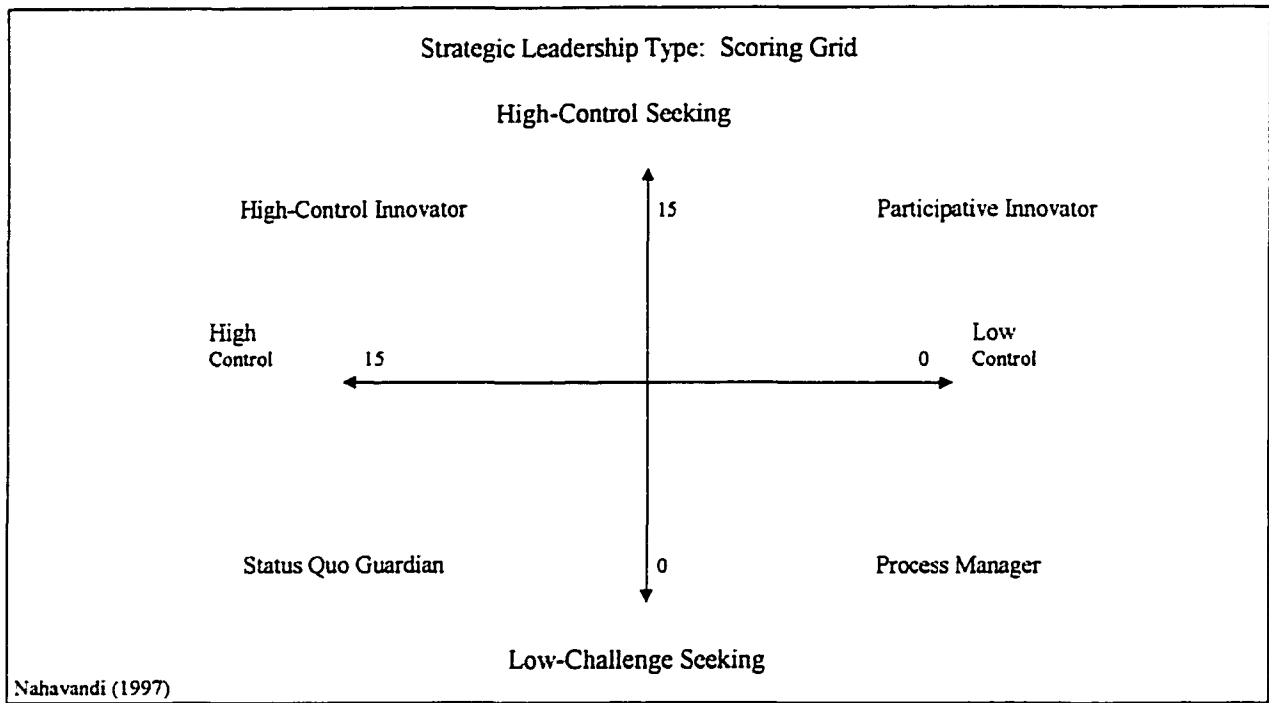
Would you be willing to participate in a follow-up telephone interview?

_____ yes _____ no

If yes, your name: _____

Your telephone number: (_____) _____

Appendix C – Strategic Leadership Grid



Appendix D – Telephone Interview Questions

1. Some people report that the use of an advisory board can muddy the process of directing a program. What role does your advisory board play? Planning... programming, etc.

If they don't have one : Some people report that an advisory board is a lot more work than they are worth. Why have you chosen not used one? Who helps in the decision making process... programming, planning, etc....

2. The use of Contract services is becoming more popular for many wellness programs. Have you used contract services?

YES: When do you find it most appropriate? And what have been the positive and negative aspects of its use.

NO: Has there been a specific reason that you have chosen not to use contract services? Who has made that decision?

3. HCI: Strategic planning and running a university wellness program takes a lot of time. How do you balance the demands of your job? Do you attend all meetings? Do you delegate responsibility to others within your program?

PI: With all the meetings, planning, budgeting, and programming demands of running a quality university wellness program, and then being asked to do so much with what is usually a small staff, How is it that you accomplish all that needs to be done?

4. Take me through the process of implementing a new program... or some kind of change in your organization... i.e. Where does the idea for change generally come from? What is the process to implement that change?
5. The literature as well as many wellness directors see changes in the way we plan on the horizon... things like ...more family-centered activities, programming reflecting different cultures, individualized programming, and programming for differing age groups.... Are these concerns built into your strategic plan, and where do you see the greatest change in this area?

Appendix E – Research Rationale for Questionnaire Part C

Literature Support

Part C of the survey instrument was added to Dr. Afsaneh Nahavandi's tool for the purpose of this dissertation. Nahavandi's instrument is designed to measure a persons strategic leadership style. To gain a wellness and/or health promotion perspective on the strategic leadership style of the directors, it was necessary to include some wellness based questions.

Listed below are the research citations for each of the statements used.

Statement 1: Rosen & Berger, 1991, pp. 172-177.

Statement 2: DeJoy & Wilson, 1995, pp. 231-238.

Statement 3: Chenoweth, 1998, pp. 108-109.

Statement 4: DeJoy & Wilson, 1995, p. 245.

Statement 5: DeJoy & Wilson, 1995, p. 255.

Statement 6: DeJoy & Wilson, 1995, p. 237.

Statement 7: DeJoy & Wilson, 1995, p. 270.

Statement 8: DeJoy & Wilson, 1995, p. 259.

Statement 9: DeJoy & Wilson, 1995, p. 222-245.

Statement 10: Chenoweth, 1998, p. 72.

Appendix F – Cover Letter to Wellness Directors

February 9, 1999

Dear Director of Employee Wellness:

Leadership in wellness and health promotion is an area that holds a certain level of interest for each of us. Research related to wellness programming already exists, yet little information related to what directors are doing strategically to lead programs into the 21st Century is available. As a doctoral student at The University of Montana, I am conducting research on the strategic leadership styles of university/college wellness or health promotion directors. This information may help us to better understand your needs, as well as the needs of other university/college wellness directors. A copy of the findings will be sent to you at the completion of this study.

If you are the director of your employee wellness or health promotion program, please complete the enclosed questionnaire. To do so should take approximately 15-20 minutes. If you are not the director of the employee wellness program at your institution, please pass the enclosed survey on to that person. Your time and effort in completing this questionnaire will make an invaluable contribution to the literature in our field. Upon completion return the form in the stamped envelope I have included. The questionnaires will remain confidential.

If you have any questions, please contact Teresa Heck at (612) 261-2121.
Thank you in advance for your participation.

Sincerely,

Teresa Washut Heck
Doctoral Candidate
The University of Montana

**Appendix G -- Letter of Support
From Ball State University**



COLLEGE OF APPLIED SCIENCES AND TECHNOLOGY
FISHER INSTITUTE FOR WELLNESS AND GERONTOLOGY

Muncie, Indiana 47306-0210
Phone: 765-285-8259 • 765-285-1293
888-WLLLSU • Fax: 765-285-8237

Dear Director of Employee Wellness:

As you are aware, there has been a great deal of research in the area of wellness programming, yet little in the area of what you, as the director, are doing strategically to lead programs into the 21st Century. Research is being conducted at the University of Montana on the strategic leadership styles of university/college wellness or health promotion directors. The National Wellness Information Resource Center is pleased to support this study being conducted by Teresa Heck and is urging your participation in completing her questionnaire.

Best wishes for good health and well-being.

Sincerely,

Neil Schmottlach

Neil Schmottlach, Ph.D.

Director

Fisher Institute for Wellness and Gerontology
National Wellness Information Resource Center
Ball State University

Appendix H – Second Cover Letter

March 12, 1999

Dear Director of Employee Wellness:

A few weeks ago you received a survey instrument regarding strategic leadership. I realize that you probably receive hundreds of requests each year, and you're probably wondering what, if anything, makes this one different. This study is specific to strategic leadership in the area of wellness. I know that you are an extremely busy person, but I am hoping you might be able to find 15-20 minutes to complete the enclosed survey. As a doctoral student at the University of Montana, I am conducting research on the strategic leadership styles of university/college wellness or health promotion directors. This information may help us to better understand your needs, as well as the needs of other university/college wellness directors. A copy of the findings will be sent to you at the completion of this study.

If you are not the director of the employee wellness program at your institution, please pass the enclosed survey on to that person. Your time and effort in completing this questionnaire will make an invaluable contribution to the literature in our field. Upon completion return the form in the stamped envelope I have included. The questionnaire will remain confidential.

Again, I truly appreciate you taking time out of your busy schedule to complete this questionnaire. If you have any questions, please contact Teresa Washut Heck at (612) 261-2121, or email: heck@sherbte.net. Thank you in advance for your participation.

Sincerely,

Teresa Washut Heck
Doctoral Candidate
The University of Montana